State of Connecticut

Governor's Cabinet

on

Nonprofit Health and Human Services

Report to

Governor Dannel P. Malloy

October 1, 2012

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GOVERNOR'S CABINET ON NONPROFIT HUMAN SERVICES

October 1, 2012

PART I: INTRODUCTION

All who have served on the Governor's Cabinet on Nonprofit Health and Human services are profoundly grateful to Governor Dannel Malloy for creating the Cabinet to help facilitate communication and enhance the public-private partnership that exists in Connecticut in order to assure opportunity, quality service, and quality of life for all of our residents. Private nonprofit human service agencies, responsible to their volunteer boards of directors and with deep roots in their local communities are the primary providers of health and human services in Connecticut.

Each year, the State of Connecticut spends over $1.5 billion on Purchase of Service (POS) contracts with nonprofit health and human service providers in order to meet the needs of state residents. The State's procurement and contract management practices and its partnership with these providers must be constructed to ensure high quality, cost-effective and sustainable services for state residents and taxpayers.

Nonprofits organizations combine the support they receive from state contracts with private philanthropy and volunteerism to deliver efficient, effective quality services in accordance with the standards established by their funding sources and the mission of their organizations.

The partnership between the State of CT and the nonprofit community must be viable and sustainable if Connecticut residents and communities are to receive services that are efficient and effective.

To achieve this end, the State's procurement and contracting processes should be fair, accountable and transparent. A balance must be struck between achieving the best possible outcomes for residents and ensuring the most effective utilization of state resources. A critical part of this balance is maintaining a nonprofit provider network that is viable and sustainable.

Connecticut's procurement, contracting, payment and quality assurance systems should provide appropriate, meaningful and ongoing opportunities for state agencies and nonprofit providers to collaboratively implement evidence-based, results-driven and financially efficient and sustainable service delivery systems.

The ultimate measure of the quality and effectiveness of our network of health and human services are the results achieved in the lives of the consumers of the services that we offer and provide. It is the

individuals we all serve and their families who should be the focus of our public private partnership and our mutual concern for responsive contract practices.

In addition we acknowledge that the presence of nonprofit organizations in our communities has a vital role to play well beyond being an effective and efficient way to deliver health and human services. They are a primary source of employment and significant contributor to Connecticut's gross domestic product (GDP). All of our nonprofits are among the uniquely American great mediating institutions of our society.

It is through volunteer boards and other opportunities for volunteerism that people come together from all walks of life to solve problems, address issues of mutual concern, improve the quality of life and provide vehicles for private philanthropy in their local communities. These mediating institutions are the very glue that cements the fabric of a healthy and prosperous society and a primary means by which core values we hold dear are transferred from generation to generation and across cultures.

It is with this in mind that through this Governor-appointed Cabinet we seek to support a healthy nonprofit sector and, with state government, work in partnership and close collaboration in the best interest of all our residents.

Toward that end, this report contains recommendations and findings that address issues important to both the state of CT, private nonprofit organizations and the philanthropic sector as we seek together to assure that vital services are sustained, that issues resulting from chronic underfunding are addressed, and that the quality of life for all - particularly the most vulnerable of our residents - is assured.

The Cabinet's specific charge as outlined by Governor Malloy in September 2011 was to provide a report in the fall of 2012 that addressed:

- How payment rates to providers are determined by the agencies and make recommendations for standardizing the methodology where appropriate. Examine how the method of setting rates reflects/does not reflect the costs involved with providing services and how that can be improved.
- The Request for Proposal and procurement processes and how they can be used to incentivize strategic partnerships in service delivery.
- The appropriate use and timing of competitively bidding contracts and how that will affect outcomes and innovative programming.
- Common cross-agency results and measures which will provide strong coordinated health and human services delivery models focused on benefits for those served.

The following pages provide recommendations for ways to address the charges noted above, along with related findings and background on the process that resulted in this report. The report also contains a number of appendices which include full reports from each of the Cabinet's three working groups.

Part II: Cabinet Members

Governor Malloy appointed the following individuals to serve on the Cabinet

Deb Heinrich*, Nonprofit Liaison to the Governor, Cabinet Co-Chair

Peter S. DeBiasi - President/CEO, *Access* Community Action Agency, Cabinet Co-Chair

Leo Arnone, Commissioner, Department of Corrections

Yvette H. Bello, Executive Director Latino Community Services

Roderick Bremby, Commissioner, Department of Social Services

William Carbone, Executive Director, Court Support Services Division of the Judicial Branch

Michelle Cook, CT State Representative

Roberta Cook, President/CEO, Harbor Health Services, Inc.

Marcie Dimenstein, Senior Director-Behavioral Health, The Connection, Inc

Robert Dakers, Office of Policy and Management

Patrick J. Johnson, Jr., President, Oak Hill

Joette Katz, Commissioner, Department of Children and Families

Terry Macy, Commissioner, Department of Developmental Services

Jewel Mullen, Commissioner, Department of Public Health

Daniel J. O'Connell, President/CEO, Connecticut Council of Family Service Agencies

David Pickus, Secretary-Treasurer, SEIU 1199NE

Maureen Price-Boreland, Executive Director, Community Partners in Action

Stefan Pryor, Commissioner, Department of Education

Patricia Rehmer, Commissioner, Department of Mental Health and Addiction Services

Nancy Roberts, President and CEO, Connecticut Council for Philanthropy

Anne L. Ruwet, CEO, CCARC, Inc

Teresa Santoro, CEO, Ridgefield Visiting Nurse Association

**Resigned as Liaison in February 2012*

Part III: Recommendations

A. Summary

The Cabinet on Nonprofit Health and Human Services' recommendations listed below were developed in three working groups described at the end of this report. Each working group presented their recommendations to the full Cabinet for action. All but one recommendation *were accepted unanimously* by the full Cabinet. The one recommendation received a majority approval. All recommendations proposed by the working groups are included in this report.

To ensure that the public-private partnership between the State of Connecticut and nonprofit providers is strong, sustainable and effective, work on these recommendations must begin in earnest and be followed through to implementation in a timely manner.

Many of these recommendations build on the recommendations and work of the Commission on Nonprofit Health and Human Services, which was convened by the Connecticut Legislature in August 2010, and conducted its work from September 2011 through March 2012 when it issued its final report.

The Cabinet's broad recommendations and summary under each heading are listed below:

1. **Adopt Principles to Guide the State-Private Nonprofit Provider Partnership:**

   The Cabinet recommends that the State of Connecticut adopt Principles to Guide the State-Private Nonprofit Provider Partnership. These Partnership Principles are intended to promote a fair, effective, responsive, transparent and accountable partnership between nonprofit providers and their state government funders. The key elements of the Principles are that:

   - All contracted services are based on dynamic, data-driven systems;
   - Selection processes for contracted providers are transparent and competency-based;
   - Contract terms and renewals are based on the community's best interest and performance;
   - Contract amounts and timely payments are critical to maintaining a viable system;
   - Reporting and monitoring promote efficiency and accountability and
   - There is open communication and mutual accountability which are critical for government and nonprofit providers to fulfill their shared commitment to the public good.

2. Adopt and Implement Cross-Agency Population Results:

The Connecticut Legislature has been using Results Based Accountability as a part of the budget appropriations process for seven years. As part of the Governor's Cabinet work, a sub-committee reviewed and developed a high level set of cross–cutting results statements that can be used in this process by all health and human services agencies.

The following two recommendations regarding Cross-Agency Population Results were adopted by the Cabinet.

- Adopt the six Population Results Statements and Headline Indicators of Success noted in this report across all health and human services agencies and purchase of service contracts executed with private, nonprofit organizations; and link all related Results-Based Accountability (RBA) reporting and analysis to these results statements. State government and nonprofit agencies can customize the Population Result Statements to focus on the quality of life of the specific populations they serve, if needed.

  The recommended results statements present a vision for Connecticut citizens and focus the following six areas: safety, economic security, health, education, support for vulnerable populations, and children. A complete set of result statements with their related indicators appear in Appendix B of the report.

- Establish a Population Results Organizing Body to implement and oversee this work. A broad and diverse group that includes representation from each branch of state government and nonprofit agencies should be assembled under the direction of an appointed coordinator.

3. Revise the State's Procurement Standards:

Consensus was reached on a number of recommendations for revisions to the current Office of Policy and Management Procurement Standards as they relate to purchase of service (POS) contracts. These recommendations include:

- Standardizing procurement practices across government branches and standardized training for all staff with procurement roles.
- Expanding considerations for waivers from competitive bidding and increasing flexibility regarding timing and justification for rebidding to assure continuity of services.
- Agencies, whenever possible, create an open planning process for service delivery that involves stakeholders. This planning will occur outside of procurement periods and provide agencies with context and considerations when developing an RFP.

4. Reporting and Data: A portion of this report focuses on data while it clearly recognizes and emphasizes that behind these numbers is the real lives of our most vulnerable residents. Recommendations include:

- Streamline data gathering by utilizing common file structures that comply with Federal requirements and maximize the use of modern electronic systems;

- Continue the ongoing effort by the State to aggregate audit and Nonprofit Strategy Platform data.
- The Office of Policy and Management should perform an annual trend report utilizing the analytical tools and all formulas applied over the past two years to examine the financial health of the private nonprofit providers. This report should be reviewed annually by the Governor's Cabinet on Nonprofit Health and Human Services.

5. **Sustainability of Private Nonprofit Providers:** In light of the chronic underfunding of private nonprofit providers of human services, the Cabinet makes the following key recommendations:
   - The state insures payment rates cover the true cost of services as mutually agreed by provider and the funding state agency in a fair and transparent manner.
   - In years without a cost of living adjustment (COLA), payment rates and service capacity should be reviewed to evaluate and respond to the changing costs where possible and appropriate.
   - Systems to better address depreciation expenses for capital improvements and/or allow for capital reserves should be established in order to maintain the infrastructure of the private provider organizations and assist during times of unanticipated dramatic increases in cost of care resulting from market forces or disaster

B. Detailed Recommendations:

1. **Adopt Principles to Guide the State-Private Nonprofit Provider Partnership -** The Cabinet recommends that the State of Connecticut adopt Principles to Guide the State-Private Nonprofit Provider Partnership. These Partnership Principles are intended to promote a fair, effective, responsive, transparent and accountable partnership between nonprofit providers and their state government funders. The key elements of the Principles appear below. The recommended Principles in their entirety appear in Appendix A.

   a. CONTRACTED SERVICES: All contracted services are based on a dynamic, data-driven system.
      i. Contracted services are based on a comprehensive and transparent planning process that defines and prioritizes services.
      ii. Contracted services balance best practices and good stewardship of public dollars with given resources.

   b. CONTRACTED PROVIDERS: The selection processes for contracted providers are transparent and competency-based.
      i. The procurement for human services is a transparent and streamlined decision-making process.
      ii. Contracts are awarded to providers that best demonstrate an ability to achieve desired outcomes through delivery of quality services.

c. CONTRACT TERMS AND RENEWALS: Contract terms and renewals are based on community best interest and performance.

i. Contract renewal is based on provider performance and demonstration of continued ability to deliver contracted services.

ii. Decisions to conduct open bidding processes rather than contract renewals consider investments required to apply for, start up, deliver, administer, and evaluate services as well as impact on existing clients.

iii. When contracts are not renewed, the transition process takes the best interests of consumers and communities into account.

d. CONTRACT AMOUNTS AND TIMELY PAYMENTS: Contract amounts and timely payments are critical to maintaining a viable system.

i. Payment is based on the full cost of efficient service delivery consistent with agreed-upon quality standards.

ii. Contracted providers providing services in accordance with contractual requirements do not bear financial risk of late payment.

iii. Payment mechanisms maximize federal dollars for the State of Connecticut.

e. REPORTING AND MONITORING: Reporting and monitoring promote efficiency and accountability.

i. Reporting and monitoring systems emphasize the level and efficacy of services for consumers.

ii. Reporting, billing, and monitoring systems are efficient and standardized across services and government agencies.

iii. Technology efficiently serves the information needs of government and service providers, including the input, reporting, and analysis of service and billing information.

iv. Providers and government agree on the best techniques to demonstrate value of services and prudent use of public funds.

f. COMMUNICATION: Open communication and mutual accountability are critical for government and nonprofit providers to fulfill their shared commitment to the public good.

i. Government and providers are proactive and responsive in their communications concerning all aspects of the contracting relationship, including opportunities and challenges.

ii. Government coordinates human services contracting activities across departments and agencies in order to enhance efficiency and effective service delivery for consumers.

iii. Government regularly makes information on human services and their results available to the public. (2)

(1) Adapted from: State of Connecticut: Commission on Nonprofit Health and Human Services (2011) Final Report, Special Act 10-5 (pp 79)

(2) Adapted from: Fair and Accountable Principles for a Sustainable Human Service System (Chicago, IL: Donors Forum, January 2010)

2. **Adopt Cross-Agency Population Results**: The six Population Results statements and Headline Indicators of Success noted in this report should be adopted across all state agencies, and all related Results-Based Accountability (RBA) reporting and analysis should be linked to these results statements. State government and nonprofit agencies can customize these Population Result Statements to focus on the quality of life of the specific populations they serve, if needed.

   NOTE: A complete set of recommended Cross-Agency Population Results statements and Headline Indicators, along with their related "Secondary" Indicators and data sources, and data development agendas, which suggest additional data to be collected and used in the future, appear in Appendix A.

   A. All Connecticut residents live in safe families and communities.
      - Headline Indicators:
        1. Per Capita Crime Rate
        2. Arrests for Domestic Violence Substantiated cases of abuse and neglect (Child & Elder)
        3. Traffic accident resulting in injury or death per capita
        4. School Safety

   B. All Connecticut residents are economically secure.
      - Headline Indicators:
        1. Unemployment rate for > 6 months and 12 months
        2. Percent of population with income less than the 200% of Federal Poverty Level
        3. Percent of all households participating in the Supplemental Nutrition Assistance Program
        4. Percent of households paying more than 30% and 50% of income towards housing costs
        5. Percent of adults with post-secondary education

   C. All Connecticut residents are developmentally, physically, and mentally healthy across the lifespan.
      - Headline Indicators:
        1. Percent of CT residents without health insurance.
        2. Premature mortality (all causes) up to age 75 or percent of CT residents who live to age 75.
        3. Percent of youth/adults who report mental health as not being good (i.e. stress, depression, and problems with emotions) during the past 30 days.
        4. Percent of children born with low/very low birth weight
        5. Percent of CT residents who are obese

D. All Connecticut residents who are elderly (65+) or have disabilities live engaged lives in supportive environments of their choosing.

- Headline Indicators:
  1. Percent of employed CT residents who are elderly (65 +) or have disabilities.
  2. Percent of CT residents who are elderly (65 +) or have disabilities and are engaged in volunteerism or other community activities.
  3. Percent of CT residents who are elderly (65 +) or have disabilities and receive care in a home based/ community setting vs. an institutional setting.
  4. Substantiated cases of abuse and neglect.
  5. High School and Post-Secondary Graduation Rates

E. All Connecticut residents succeed in education and are prepared for careers, citizenship & life.

- Headline Indicators:
  1. Percent of Entering Kindergarteners Needing Substantial Instructional Support
  2. Percent of 3rd graders at or above Goal on CMT Reading and Math
  3. Cohort High School Graduation Rate
  4. Percent of 16-24 year olds employed, in school, or in the military
  5. Percent of population age 25-34 with a college degree)

F. All children grow up in a stable environment, safe, healthy, & ready to succeed *(for detail, see CT Kids Scorecard found in Appendix B*).

Additionally, establish a Population Results organizing body to implement and oversee this work. A broad and diverse group that includes representation from each branch of state government and nonprofit agencies should be assembled under the direction of an appointed coordinator.

3. **Revise the State's Procurement Standards**: The following consensus recommendations relate to the current Office of Policy and Management Procurement Standards. The pages and sections noted are where the items appear in the Standards. It is understood that some of these recommendations may require statutory changes.

   a. Applicability: (Page 4) The Judicial Department should adopt the Procurement Standard used by the Executive Branch. While Judicial is a separate branch of government and as such is not are required to adhere to these standards, the standards include many best practices and their use improves consistency of contracting.

   b. Training: (Page 6, H.3) All agencies should utilize standard training for all staff that has procurement responsibilities. Investigate web-based training to reduce costs and improve efficiencies, and provide additional materials to address agency-specific policies and procedures when appropriate.

   c. Sole Source Contracts: (Page 8) Do not require waivers for contracts of $50,000 or less rather than $20,000; and two years in duration rather than one year. Increasing the dollar limit and length of contract will save time and resources for both the state and providers.

d. Waivers from Re-Procurement: (Page 9). Add to considerations for waivers items such as evidence-based models which require significant investment at the provider level. Ensure that the list of considerations for waiver that appear in the procurement standards is consistent with the options available to state agencies listed in the forms used to request waivers.

e. Procurement Schedule: (Page 12) Use the contract monitoring and oversight systems, rather than re-procurement to address poor-performing providers. If it is determined that due to underperformance re-procurement is necessary for a particular geographic service area, re-bid only that area and the entire State.

f. Evaluating the Need: (Page 15) Use the below language to more concisely and clearly describe when a state agency should engage a contractor:

Before entering into a contract, an agency must first evaluate the need to do so. If an agency's existing employees lack the necessary expertise, or are already fully committed to other responsibilities, a state agency may choose to purchase services through a contract. An agency should also consider whether another State agency has the resources to provide the service, or whether it is possible to purchase it on a cooperative basis with other State agencies.

State agencies should consider the following factors when determining if they should engage a contractor: (1) the need for outside expertise, (2) the lack of internal resources, or (3) the need for independent judgment or objectivity. In terms of expertise, a contractor can provide special skills or knowledge that an agency's regular, full-time employees do not possess. In terms of resources, a contractor can provide a needed service without diverting the efforts of regular employees who may be already committed to other responsibilities. In terms of objectivity, a contractor can provide an unbiased view of an agency's operations, identify problem areas, or suggest improvements. (add a note - this section relates to PSAs, Not POS Contracts)

g. Writing the RFP: (Page 20). Procurement procedures should be grounded in an overall planning process. State agencies should:

i. Develop forums for ongoing communication with providers on their service system design and potential changes (i.e. DCF's Continuum of Care Partnership).

ii. Have the option of a "state planning process" prior to the writing of the RFP, to utilize the expertise of stakeholders to determine models, design and program details.

iii. Develop a process that would result in information similar to that gathered from a Request for Information, but would be less formal and arduous for providers. A state agency could identify a particular need and interested parties, invited through a public posting on the DAS website, to meet to discuss and recommend models to address that need.

h. Evaluation Criteria: (Page 24). Clearly identify weighting criteria for all applications. This can be accomplished by removing the second paragraph on page 24. Revealing the weighting to all applicants is fair and knowing the "weight" of each question will allow applicants to better understand priorities of the requesting agency, and assess their own ability to submit a competitive application.

i. Contractor Selection: (Page 34) Allow the selection committees the option to submit to the agency head for consideration a full list of recommended proposals when appropriate, rather than a maximum of the "top three". This would include when an agency may be selecting multiple providers to provide services.

j. Contractor Selection and Timeline: (Page 34) Strengthen language to require State Agencies and providers to make a good faith effort to complete contract negotiations within 45 days of notification of the winning bid.

k. Debriefings: (Page 36). Treat debriefings as an opportunity to provide proposal feedback to applicants, including how the application ranks compared to the winning proposals.

l. Monitoring Contractors: (Page 37) Add the following "bulleted" statement - Collaborative discussions geared towards service delivery improvement.

m. Notification of Bid Outcomes: Require State agencies to post notifications of winning proposals on their websites to improve communication and transparency.

n. Submission of Proposals: Require State agencies to accept electronic submission of proposals whenever practical, to improve efficiency and reduce costs.

o. Technical recommendations:

   i. On page 21, amend statement to recognize that OPM has developed a standard RFP template.

   ii. Remove "Screening Committee" on page 24 and 25. Screening Committees do not typically review rating sheets prior to an RFP release.

   iii. Remove the second sentence in the definition of "End Users." It is inaccurate.

4. **Reporting and Data**: Implementation of the following recommendations will help to preserve quality services and assure the financial viability of Connecticut's nonprofit health and human service providers. All but the final recommendation in this section were adopted by consensus.

   a. Require State Agencies to develop and implement a written plan to standardize financial reporting requirements for all providers that includes deadlines for the plan's development and implementation, and reportable outcomes for such standardization.

   b. Consider the impact of all new administrative requirements *prior* to implementation, and require State Agencies to work with providers to mitigate the impact of any new requirements.

   c. Require all State Agencies where appropriate to pursue avenues to take advantage of the common file structure in their data collection systems that will result from a July 1, 2014 requirement that many Providers must have systems in place that comply with Federal

   d. Meaningful Use Requirements. Require that the systems allow for standardized and secure upload.

   e. Provide ongoing aggregation of audit data by the State and review of the CT Non Profit Strategy Platform data. The Office of Policy and Management should perform an annual

trend report supported by the CT Non Profit Strategy Platform that will be reviewed annually by the Governor's Cabinet on Non Profit Health and Human Services.

5. <u>Sustainability of Private Nonprofit Providers</u>

a. Allow not-for-profit organizations to have and maintain Capital Reserve Accounts not subject to audit recoupment as approved by State Agencies.

b. Cost standards for real estate should be reviewed and revised. Areas to be considered include but not limited to a land fair rental factor, and supplemental funding once depreciation and interest no longer meet a typical mortgage cost.

c. Create a system for approving no-cost budget revisions that is standardized across all agencies.

d. Ensure that payment rates cover the true cost of service as mutually agreed by provider and the funding State Agency in a fair and transparent manner. In years without a COLA, payment rates and service capacity should be reviewed to evaluate and respond to the changing costs where possible and appropriate.

   i. Extraordinary one time increases in essential costs should be considered for supplemental funding, similar to what has been given to grantees for fuel relief in the past. This does not make a commitment to sustaining an increase from year to year like a COLA increase but does recognize fixed costs that are outside of a provider's control and offer some relief.

   ii. The provider community and the state Agencies should discuss ways to allow providers to have a greater benefit in the state funding system through depreciation or other means where it is of mutual interest. Donated real estate is an opportunity for nonprofit providers to improve their financial situation. Current cost report rules result in the State rather than the provider deriving the primary annual benefit of such a donation.

e. *(Approved by a majority of the Cabinet)*: Allow surplus retention up to a defined amount for providers that meet performance outcomes and receive agency approval. This allows risk to be shared by both the state and providers. Toward this end, employ safeguards to ensure this is not attained by holding down wages and benefits or constriction of services, while allowing providers the opportunity to retain some savings through careful management. Partial surplus retention encourages good business practices and allows for a portion of unspent contract dollars to be reinvested into the provider infrastructure on which the State and its residents depend.

6. **<u>Automatic Rebidding of Purchase of Service Contracts</u>:** Additionally, the Cabinet deliberated the merits of recommending changes to the statute that governs the automatic rebidding of Purchase of Service Contracts. Some felt that the opportunity for State Agencies to seek waivers from the Office of Policy and Management is adequate. Other advocated for allowing each State Agency the authority to decide whether or not to rebid these contracts. No vote was taken on this matter and the Cabinet recommends more discussion and deliberation on this topic is needed in the future.

PART IV: BACKGROUND

The Cabinet met for the first time on December 6, 2011 to begin its work. Minutes of all meetings were posted to Cabinet's website at www.ct.gov/opm and can be reviewed by visiting that site.

Early in the process the Cabinet agreed to convene three working groups to carry out the specific charge of the Cabinet and report their findings and recommendations to the full Cabinet the working were:

- Request for Proposals and Procurement Processes
- Rate Setting
- Cross-Agency Results

Cabinet members or their designees served on the working groups along with two additional members appointed by the each working group co-chair. The Working Group Co-chairs, one each from the private and public sector were appointed by the Cabinet co-chairs. The full membership of each working group is noted in the appendixes.

The working groups met between Cabinet meetings, updating the full Cabinet at the Cabinet's bi-monthly meetings. Final Working Group Reports were presented to the full Cabinet for review and action during the Cabinet's May and June meetings.

The decision making process for accepting working group reports was as follows:

- The Cabinet and its working groups shall endeavor to reach consensus on the items for inclusion in the final report.
- If consensus cannot be reached voting will be used.
- A quorum equal to no less than 50% of the Cabinet members must be present for any vote and/or decision to be valid.
- To be included as part of the final report, a recommendation must receive a vote of the majority of the quorum present.
- Only members of the Cabinet are eligible to vote on Cabinet decisions, and only work group members are eligible to vote on working group decisions. Proxy votes are not valid.
- Only those recommendations approved by the Cabinet will be included in the Cabinet's year-end report.

This report was reviewed and unanimously accepted by the Cabinet at its September 24, 2012 meeting.

PART IV: Working Group FINDINGS

A. Cross-Agency Population Results Working Group: Much of the early work of the Working Group focused on creating a comprehensive inventory of Population Results Statements (also known as *Quality of Life Results*). Over thirty existing Population Results Statements submitted by Health and Human Services agencies were categorized in one of thirteen initial domains. For clarity and communication power, the results statements were ultimately arranged in five domains and working groups were formed with the charge of developing a single results statement for each domain. The working group results statement recommendations (found in Appendix A) mirrored much of the work done in Connecticut to date.

Second, each of the five Population Results Statements includes suggested headline and secondary indicators that will help to identify progress toward each result. These indicators are provided as an initial list of possible indicators for each results statement. The development of indicators at the population level of RBA is often an iterative process, dependent on data availability and quality. This process will likely include the creation of a Data Development Agenda that included data not currently collected or available.

Third, the Working Group unanimously voted to acknowledge and include the work of the Select Committee on Children's RBA Report Card as a sixth Population Results Statement. The Working Group found substantial overlap with the RBA work of the General Assembly's Appropriations Committee and the Select Committee on Children. This report card has been the product of a diverse working group that includes representatives from the General Assembly, the executive and judicial branches, the nonprofit sector, local government, parents, child advocates and higher education. Addressing children from birth to age 18, this report card provides both a result statement and well-refined headline and secondary indicators, which are being publicly reported.

A copy of the Children's Report Card can be found in *Appendix A.*

Finally, The Connecticut Data Collaborative offered to support the Governor's Cabinet on Nonprofit Health and Human Services in reporting indicators for the cross-agency population results statements adopted by the Cabinet. When the indicators are finalized and technically defined (operationalized), the Collaborative will work with the relevant state agencies to obtain the necessary data on an ongoing basis and will add the indicators to the Data Catalog on the Collaborative's web site, ctdata.org. In addition, the Collaborative will create for the Cabinet a customized data portal on ctdata.org where the public can easily access and visualize the indicators by result.

B. Request-for Proposal and Procurement Processes Working Group found that the procurement standards included many mechanisms for flexibility with regards to Purchase of Services (POS) contracts including some meaningful rationales for considerations of waiver from competitive bidding. However, the group felt there are other rationales that should be included. The group also felt that the procurement schedule required of all agencies may not always maximize benefits for clients that receive services through POS contracts.

The working group recognizes that a healthy private nonprofit sector is vital to the well-being of the citizens of Connecticut. Nonprofit Health and Human Service providers and state government must work collaboratively as partners to assure the provision of high quality, essential services to Connecticut's most vulnerable citizens. The working group adapted partnership principles that it feels will help facilitate a true partnership that can assist all of us to fully embrace and utilize established results based accountability practices to demonstrate meaningful and appropriate outcomes for all state funded programs.

C. <u>Rate Setting Working Group</u>: The evident consistent pattern of underfunding with less than 1% per year on average for over 20 years and just over 2% for the period 2000 to 2011, (see chart from Connecticut Community Providers Association) of community based nonprofit providers of health and human services in CT continues to leave the majority of these providers of vital services in a weakened and in some cases precarious financial position, with only 34.95% in the sample of 2010 audits reviewed having the recommended operating reserve ratio of 25% or more, with 19.8% being below 10% and 15.1% below zero. In its 2009 national study of nonprofit contracting, Urban Institute data ranks Connecticut as the 7th worse state in the nation when it comes to state contracts covering the full cost of contracted services. In addition, 73% of nonprofit agencies in CT with budgets of $1 million or more are in deficit compared with 40% nationally in 2009. (According to the audit sample data for 2010 a reported deficit occurred in 43% of the data). The trend from 2009 to 2010 in general is not encouraging. The number of nonprofit agencies not meeting acceptable operating reserves grew from 60.39% in 2009 to 67.44% in 2010. These overall poor results indicate that more providers are experiencing chronic cash shortages. The debt ratio also increased from 54.54% to 57.95% from 2009 to 2010 making providers less attractive for financing opportunities. 66.27% of all providers current liquidity ratio indicates that they would have difficulty meeting their short term obligations.

The working group also examined ten years of trend data with almost 300 providers in the sample supplied by the Urban Institute utilizing some of the same ratio analysis for financial stability that we applied to the audit data. The Urban Institute data is based on annual 990 form filings done by all 501-C-3 corporations for the IRS who meet the reporting requirements. Trend data indicates a deterioration of financial stability over the ten year time frame. For example the Savings Indicator average in 2000 was 5% on average. In 2010 it had dropped to 2%. The percentage of providers with substandard ratings increased from 55% to 72%. Thus they are in danger of going out of business with any event that causes a financial reversal. The Surplus Margin Ratio in 2000 was 3% with 55% of all providers having a substandard score. In 2010 the average score had dropped to 1% with 72% of all providers having a substandard score. Thus, with an average surplus margin of 1% there is little or no opportunity for reinvestment or ability to establish a safety net.

The combination of increasing fixed costs such as utilities, rent, employee benefits, fuel, etc while state reimbursement remains flat is the major contributor to these ratios and fiscal challenges. Many providers have indicated that they have responded to these fiscal issues through reduced benefits, flat wages for employees and neglect of infrastructure while spending down reserves. It is particularly problematic for their lower paid direct care employees. The work is physically and emotionally taxing and these personal care attendants, child care workers,

group home workers, nursing assistants, etc. face similar financial challenges as the people they serve. The vast majority are women.

The work group is seeking information related to how many private provider workers are qualifying for public assistance such as Husky Health plans, Medicaid, and food stamps due to low income. In addition many are reportedly working part time with few or no benefits and are working multiple jobs, oftentimes creating the potential for unsafe conditions due to lack of sleep. Since wages and benefits constitute 70% to 80% of operating budgets in private community nonprofit service providers, they face a Sophie's choice. Cost reductions to balance budgets must come from wages and benefits or cut programs to maintain services and assure fiscal viability.

Also, some state agencies do not pay contractors in a timely manner consistent with agreed upon timeframes and thereby create additional hardships and costs of borrowing for nonprofit service providers. The Urban Institute data indicates 43% of nonprofits in CT report late payments. This compares with 41% national average. An additional serious concern is the neglect of infrastructure as physical plants are neglected to keep budgets in balance. Thus roofs, mechanical systems, and basic maintenance are extended beyond prudent limits.

It is important to recognize that community nonprofit human service providers are charitable organizations recognized by the Federal Government as 501-C-3 agencies exempt from taxation and governed by volunteer boards of directors made up of local residents representative of the communities within which they are based. These boards and the donors they cultivate contribute significant private charitable dollars and untold volunteer hours to supplement the quality and extent of care in addition to state revenue. From a historical perspective, to contract with community nonprofit human service providers is, in reality, to contract with and reinvest in the community itself in the interest of the common good. It is neither reasonable nor possible for private charity to supplant the state's responsibility with respect to caring for its most vulnerable citizens.

1. STATISTICAL FINDINGS AND TRENDS: Ratio Analysis Eleven-Year Trend

In effort to assess the impact of the financial environment on the Non Profit Provider Community and how this has impacted operations, the Committee performed an analysis of financial ratios over the 11 year period of 2000 to 2010. The Committee felt exploring results of long term trend data analysis was important because of the reaction to last year's report from the Commission on Nonprofit Health and Human Services, Private Provider Cost Increases, Nonprofit Agency Financial Condition and Sources of Revenue Working group Report**.** The report included the previous year's financial ratios for a statistically sound representation of 101 providers. The ratios painted an unfavorable picture of the financial health of the Private Nonprofit operations that indicated that the Private Nonprofits were working very close to the margin.

The reaction to these findings was that there is a belief that most providers have regularly functioned very close to the financial margin and this was business as usual. The Providers indicated they found themselves becoming increasingly financially unstable and were

concerned about their ability to continue to provide quality services in a safe environment. Although many providers over the years have struggled to remain in the black and provide a quality service, events in the past several years has caused many new providers and become part of the majority of providers that have poor financial indicator scores.

The goal of this 11 year span analysis is to provide a concrete analysis of the financial position of the provider community and it will allow a determination to be made if the current financial status is business as usual or if Providers are actually operating in a declining environment that is unprecedented. The following are the results of this analysis:

a. **Leverage Ratio**

The Leverage Ratio is financial ratio that calculates an organizations end of year liabilities over the end of year assets. (EOY Liabilities/EOY Assets).

During the 11 year span the providers have seen a significant change in their financial position. In 2000, 42% of all providers had a substandard rating. In 2005, the ratio experienced a jump with 46% of providers having a substandard score and in 2010, 51% of all providers had a substandard rating. The average score in 2000 amongst all providers was 53%, while the score increased to 62% in 2010. These results not only indicate that 9% more providers find themselves with a substandard leverage score, carrying too many liabilities for their level of assets but also, the providers on average have scores that are 15% worse than they were 11 years ago.

Although there was an increase in the score in 2005 there had been a recovery in subsequent years. Beginning in 2008, the scores steadily worsened and were at their worst in the last year of the analysis in 2010. The years where providers showed sharp declines in their financial health were preceded by a year with no cost of living increase.

Substandard Ratio: **Leverage** (EOY Liabilities/EOY Assets) **>50%**					
Year	Appropriated COLA	Providers w/ Substandard Ratios	Total Sample	Percent w/ Substandard Ratio	Average
2000	3%	114	269	42%	53%
2001	1%	101	260	39%	47%
2002	4%	125	286	44%	48%
2003	2%	129	289	45%	52%
2004	0%	126	291	43%	53%
2005	2%	134	294	46%	56%
2006	4%	135	297	45%	61%
2007	2%	122	295	41%	53%
2008	3%	134	293	46%	55%
2009	0%	141	290	49%	58%
2010	0%	140	274	51%	62%

b. **Savings Indicator**

The Savings Indicator demonstrates an organization's ability to save funds to reinvest in programming and withstand any potential emergency situations that might arise and financially threaten an organization's operations. (Net Income/Total Expenses)

In 2000, the average savings indicator over the provider network was 5%. In 2010, the average savings indicator has dropped to 2%. This is a dramatic loss in an organizations ability to react to new expectations in doing business, service development and the ability to withstand a disastrous event. During the same period of time the percentage of providers with substandard ratings increased from 55% to 72%. Clearly the vast majority of all providers no longer has the funds available to adapt to meet the new service landscape and may not recover from an incident that causes a financial reversal.

The Savings Indicator reached its lowest level in 2004 with a reported high number of providers with substandard scores. This score were likely impacted by 2004 being a year without a cost of living increase. Since providers received COLAs from 2005 to 2008, this ratio improved during this time. At the end of the 11 year period in 2009 and 2010, the scores once again dropped.

The lack of an ability to save coupled with a very high leverage ratio, means it is unlikely the providers will have the savings necessary to withstand an emergency and will likely not be able to borrow additional funding to cover the necessary expenses.

Substandard Ratio: **Savings Indicator** (Net Income/Total Expense) **<2%**					
Year	Appropriated COLA	Providers w/ Substandard Ratios	Total Sample	Percent w/ Substandard Ratio	Average
2000	3%	147	269	55%	5%
2001	1%	142	260	55%	4%
2002	4%	177	286	62%	3%
2003	2%	197	289	68%	1%
2004	0%	205	291	70%	1%
2005	2%	198	294	67%	2%
2006	4%	191	297	64%	2%
2007	2%	184	295	62%	4%
2008	3%	183	293	62%	4%
2009	0%	207	290	71%	1%
2010	0%	196	274	72%	2%

c. Surplus Margin Ratio

The Surplus Margin Ratio, measures the amount of net income over total revenue, also known as pure profit. (Net Income/Total Revenue)

In 2000 the average score was 3% with 55% of all providers having a substandard score. In 2004, the number of providers with substandard scores spiked at 71%. This percentage recovered in 2005 when the COLA was reinstituted. By 2010, the average

score had dropped to 1%, with 72% of all providers having a substandard score. Similarly to the previous two ratios, the beginning a trend towards financial instability occurred in 2009 with the number of substandard scores peaking for 2009 and 2010. In 2000, there was a small ability to put aside funds for emergencies to or to reinvest in programming. By 2010, with the average surplus margin at 1% there is little or no opportunity for reinvestment or ability to establish a safety net.

Substandard Ratio: **Surplus Margin** (Net Income/Total Revenue) **Ratio <0**					
Year	Appropriated COLA	Providers w/ Substandard Ratios	Total Sample	Percent w/ Substandard Ratio	Average
2000	3%	147	269	55%	0.03
2001	1%	143	260	55%	0.03
2002	4%	178	286	62%	0.02
2003	2%	198	289	69%	0.00
2004	0%	206	291	71%	0.01
2005	2%	200	294	68%	0.01
2006	4%	191	297	64%	-0.01
2007	2%	186	295	63%	0.02
2008	3%	183	293	62%	0.02
2009	0%	209	290	72%	0.00
2010	0%	197	274	72%	0.01

7. A Year Later - Focus on SFY2009 and SFY2010 Comparisons

Below is a revisiting of the financial condition of providers selected for financial ratio testing as part of the work of the Commission on Nonprofit Health and Human Services, reported in 2011.

The providers were divided into three sample groups comprise of those who received State funds and had annual revenues as follows:

- *Group I: $300,000 to $2,000,000 (32% of sample)*
- *Group II: $2,000,000 to $10,000,000 (37% of sample)*
- *Group III: over $10,000,000 (32% of sample)*

Eighty-six of the original 101 providers submitted audits for SFY2010. The following financial ratios tested against the SFY 2009 sample group are discussed below.

a. Liquid Funds Indicator (LFI) = Total Net Assets - Restricted Net Assets - Fixed Assets/Average Monthly Expenses: The liquid funds indicator determines the number of months of expenses that can be covered by existing assets, without the use of restricted funds. The benchmark for a favorable rating is a minimum of 1 month assets or a LFI score of 1 or more. This ratio has been used more often with nonprofit providers than the Defensive Ratio, because it does exclude restricted funds, that may not actually be

available to cover operating expenses. Restricted funds are more common in the nonprofit environment than in the private sector in general because of restrictions set by donors and by the provider's board.

Synopsis of Results: Although the vast majority of providers continue not to have an acceptable level of assets to cover one month of operating expenses, there was a slight improvement in this ratio overall. The average mean score in 2009 was .71. It increased to 1.25 in 2010, with the median being .84, in 2009, and improved to 83 in 2009.

Liquid Funds Indicator (LFI)		
Year:	*2009*	*2010*
Group 1	*N=32*	*N=14*
Median	-0.08	-0.21
Mean	0.53	0.62
% of Providers below an Acceptable Range	58%	57%
Group 2	*N=37*	*N=39*
Median	-0.08	-0.21
Mean	0.53	0.62
% of Providers below an Acceptable Range	58%	57%
Group 3	*N=32*	*N=33*
Median	-0.27	-0.84
Mean	0.53	0.78
% of Providers below an Acceptable Range	94%	85%
Combined Results	*N=101*	*N=86*
Median	-0.84	-0.83
Mean	0.71	1.25

Operating Reserve Indicator (OR) = Operating Reserves/Annual Operating Expenses (OR)**:** Operating Reserves are the portion of the unrestricted net assets that are available for use in cases of emergency to sustain financial operations, in the case of an unanticipated event of significant unbudgeted increases in operating expenses or losses in operating revenues. An acceptable minimum OR score is 25%.

Synopsis of Results: Groups 1 and 2 both had increases in the percentage of providers that no longer met the 25% target for operating reserves. Group 3 had a very slight improvement with 71.88% of providers not meeting the target in SFY09, and 69.69% of providers not meeting the target in SFY10. Overall the percentage of providers that now no longer meet the target has increased from 60.39% to 67.44%. These overall poor results indicate that more providers are experiencing reserve shortages, and or higher expenses that have not been matched by reserve increases. Organizations with these OR scores are not in a position to engage in long range planning and opportunities, but rather are concerned with the current stability of the organization. This negatively impacts the service network.

Operating Reserves Ratio (OR)		
Year:	*2009*	*2010*
Group 1	N=32	N=14
Median	22%	14%
Mean	35%	30%
% of Providers with Scores Less than 25%	53%	64%
Group 2	*N=37*	*N=39*
Median	19%	16%
Mean	35%	27%
% of Providers with Scores Less than 25%	57%	67%
Group 3	*N=32*	*N=33*
Median	10%	13%
Mean	23%	25%
% of Providers with Scores Less than 25%	72%	70%
Combined	N=101	N=86
Median	12%	14%
Mean	31%	27%
% of Providers with Scores Less than 25%	60%	67%

Debt Ratio (DR) = Average Total Debt/Average Total Assets: The Debt Ratio measures the proportion of assets provided by debt. High values indicate future liquidity problems or reduced capacity for future borrowing. The higher ratios indicate the risk to potential lenders and would cause lenders to need to increase their rate of return to mitigate the risk. Historically high risk borrowers have to pay higher interest rates if they can borrow at all. Providers that have to pay high interest rates or cannot borrow, cannot actively compete for new types of business and are more harshly impacted by changes in the payer mix that require they invest in administrative and infrastructure changes.

If the ratio is less than 0.5, most of the provider's assets are financed through equity. If the ratio is greater than 0.5, most of the company's assets are financed through debt. Organizations with high debt/asset ratios are said to be "highly leveraged," and have low liquidity. An organization with a high debt ratio (highly leveraged) would find it difficult to continue to operate if creditors started to demand repayment of debt.

Synopsis of Results: The percentage of providers with Debt Ratios over .5, in Group 1 increased from 41.94% to 50% from 2009 to 2010. In Group 2, there was a slight decrease from 55.26% to 53.85% and in Group 3 it increased from 65.63% to 69.70%. Overall the provider community increased from 54.54% to 57.95%. A Debt Ratio over .5 makes the providers less attractive for financing opportunities. One might have expected more slippage in this ratio than actually occurred but many of the providers have reported that their lending institutions now consider state funded businesses to be higher risk businesses than they would have been considered in the past. They have not been able to secure financing, which in turn, causes their debt ratio to remain relatively the same. A high debt ratio coupled with not having a safe amount of operating reserves available puts a provider in a precarious financial position.

	Debt Ratio (DR)		
	Year:	*2009*	*2010*
Group 1		*N=32*	*N=14*
	Median	0.35	0.44
	Mean	0.53	0.51
	% of Providers with Scores .5 or Higher	42%	50%
Group 2		*N=37*	*N=39*
	Median	0.53	0.6
	Mean	0.59	0.61
	% of Providers with Scores .5 or Higher	55%	54%
Group 3		*N=32*	*N=33*
	Median	0.59	0.59
	Mean	0.62	0.59
	% of Providers with Scores .5 or Higher	66%	70%
Combined		*N=101*	*N=86*
	Median	0.54	0.55
	Mean	0.58	0.59
	% of Providers with Scores .5 or Higher	55%	58%

Current Ratio (CR) = Current Assets/Current Liabilities: The current ratio is an indication of liquidity and ability to meet creditor's demands. A ratio of below 1 indicates difficulty meeting short term obligations. A ratio of 2 is generally considered to be acceptable.

Synopsis of Results: The Group 1 scores indicated that 41% would have difficulty meeting creditors' demands in SFY 09. This percentage increased to 71% in SFY10. This change indicates the once more financially stable Group 1 is more in line with Groups 2 and 3. While Groups 2 and 3 had slight improvements, the percentage of agencies having scores below 2has remained steady over the two year period at approximately 66%.

	Current Ratio (CR)		
	Year:	*2009*	*2010*
Group 1		*N=32*	*N=14*
	Median	2.29	1.66
	Mean	9.29	8.68
	% of Providers with Scores Below 1	25%	21%
	% of Providers with Scores Below 2	41%	71%
Group 2		*N=37*	*N=39*
	Median	1.32	1.29
	Mean	2.65	3.12
	% of Providers with Scores Below 1	37%	26%
	% of Providers with Scores Below 2	76%	67%
Group 3		*N=32*	*N=33*
	Median	1.48	1.61
	Mean	2.11	2.81
	% of Providers with Scores Below 1	13%	18%
	% of Providers with Scores Below 2	75%	73%
Combined		*N=101*	*N=86*
	Median	1.49	1.47
	Mean	4.59	3.91

8. Summary Findings of Financial Analysis

a. The 11 Year Trend Analysis illustrates that the provider community has experienced a financial decline from the year 2000 to the year 2010.

b. Years without COLAs present a financial hardship to the providers. Repeated, successive years without COLAs have been difficult for providers to manage. During this period they have reduced expenses, like health care benefits to employees to be able to balance revenues and expenses. Opportunities for savings in their operations have been exhausted and there is little likelihood that continued operation without increases can be managed without service reductions.

c. A lack of funding increases that matches increases in expenses erodes the provider network's ability to change to meet service needs and reinvest in the network.

d. Rates should be set at a minimum to cover the costs of care. To create a strong network that can make the required system changes will require that providers are actually able to retain income for reinvestment.

e. In a service network that is moving to evidenced based service models, forced deviation from the model due to a lack of funding cannot be tolerated. The rate must be adequate to provide the service as outlined by the evidenced based practice to have the desired results.

PART VI: CONCLUSION

Building a strong and sustainable partnership between the State of Connecticut and the nonprofit sector is vital to the future health and wellbeing of all our state's residents. The recommendations of this Cabinet are designed to move us forward in this critical journey.

This work and the recommendations contained in this report build on the related work of the legislatively created Commission on Nonprofit Health and Human Services. In some cases it expands on the recommendations contained in those reports and in others, new recommendations are made.

We understand that some of these recommendations are administrative in nature, and some may require legislative changes. Still others, like the adoption, dissemination and integration of Populations Results Statements and Indicators throughout State Agencies will require perseverance, and leadership at all levels of State government.

One of the very positive results of the Cabinet deliberation process has been the productive and insight producing opportunities for leaders from both Nonprofits and State Agencies to discuss and debate topics among and between them, which in many cases has not occurred in recent memory.

The full Cabinet thanks Governor Malloy for *his* leadership and vision in creating this Cabinet as the vehicle by which ideas have been and will continue to be vetted. The model of a Nonprofit Liaison serving as co-chair of a Cabinet comprised of the leaders of State Agencies and Nonprofit organizations has become a model already being replicated in other States.

We believe that this work must continue. Implementation of recommendations will take ongoing commitment, advice and contributions from both State employees and nonprofits staff and board members. We look forward to meeting this challenge in the months and years ahead.

APPENDIX A

Recommended Principles to Guide the State-Private Nonprofit Provider Partnership

Principles to Guide the State-Private Nonprofit Provider Partnership - The Cabinet recommends that the State of Connecticut adopt the following Principles to Guide the State-Private Nonprofit Provider Partnership. These Partnership Principles are intended to promote a fair, effective, responsive, transparent and accountable partnership between nonprofit providers and their state government funders.

1. CONTRACTED SERVICES: All contracted services are based on a dynamic, data-driven system.
    a. Contracted services are based on a comprehensive and transparent planning process that defines and prioritizes services.
        1. Planning includes local and regional input from consumers, providers and state agency representatives.
        2. Planning is coordinated across service and funding areas.
        3. Planning is conducted at a minimum of every 10 years based on the most recent census data, and no more frequently than every five years.
        4. Public funding is allocated across services, geography, and populations based first on existing needs, with consideration of emerging needs, service gaps, and disparities.
    b. Contracted services balance best practices and good stewardship of public dollars with given resources.
        1. There is a system to uniformly describe services and identify consistent terminology for use in budgeting, contracting, reporting, and evaluating.
        2. Government and service providers participate in a formal process to identify, define, and communicate best, informed, and promising practices for contracted services. (e.g. DMHAS Practice Improvement Initiative)
        3. In determining contracted services, government considers both short- and long-term benefits to consumers and communities, given available resources.
        4. Contracted services are assessed according to the relative benefits to the consumers and communities, the number of potential beneficiaries, and the severity and/or extent of need.
        5. Where communities do not have the infrastructure to deliver the necessary level or types of services, public dollars are invested in building the capacity of providers to deliver effective services.
        6. Government invests in innovative services and service models for providers to achieve desired results.

2. CONTRACTED PROVIDERS: The selection processes for contracted providers are transparent and competency-based.
    a. The procurement for human services is a transparent and streamlined decision-making process.
        1. Government establishes grant criteria and contract award processes in advance and adheres to request for proposal (RFP) processes.
        2. Government consistently applies standards and policy to determine contract awards across providers.
        3. Potential bidders receive adequate notice of funding opportunities at a designated state website (e.g. State agency and DAS Procurement Portal).

4. Each request for proposal includes explicit guidance on eligibility qualifications for service providers, and all qualified, interested providers have the opportunity to apply.
5. Paperwork is reduced and duplication is minimized through a shared use of a common data bank.

b. Contracts are awarded to providers that best demonstrate an ability to achieve desired outcomes through delivery of quality services.
   1. Criteria for selecting providers include experience with service delivery, utilization of appropriate best practice or innovative models, investment in infrastructure, qualified staff and a track record of delivering the agreed-upon outcomes.
   2. Selected providers demonstrate specific experience with, or knowledge of, the work specified, the target population(s), community, or region; community and consumer support; and cultural competency.

3. CONTRACT TERMS AND RENEWALS: Contract terms and renewals are based on community best interest and performance.
   a. Contract renewal is based on provider performance and demonstration of continued ability to deliver contracted services.
      1. There is a system for defining and measuring acceptable and excellent performance, including consumer satisfaction.
   b. Decisions to conduct open bidding processes rather than contract renewals consider investments required to apply for, start up, deliver, administer, and evaluate services as well as impact on existing clients.
      1. The renewal process minimizes duplicative paperwork by allowing providers to certify where there are no changes to corporate legal and organizational status.
      2. Rebidding of contracts is based on principles associated with service quality and cost-effectiveness and fairness associated with the procurement process and on appropriate re-procurement cycles for services subject to rebidding.
   c. When contracts are not renewed, the transition process takes the best interests of consumers and communities into account.
      1. Timeframes for government communication about the non-renewal of a contract allow for coordination between terminated and new providers to provide continuity of care for consumers.

4. CONTRACT AMOUNTS AND TIMELY PAYMENTS: Contract amounts and timely payments are critical to maintaining a viable system.
   a. Payment is based on the full cost of efficient service delivery consistent with agreed-upon quality standards.
      1. Payment for services is set in a fair and transparent fashion with clear methodology for assessing the full costs of service delivery and with the opportunity for providers to provide input on the methodology.
      2. Where possible and appropriate, payment may be adjusted to reflect differences of geography and/or consumer needs, to the extent that they impact the cost to deliver service.

3. Payment may be adjusted to reflect a level of quality or performance above a defined baseline.
4. Budgets are reviewed and adjusted annually to reflect changing costs of service delivery.
5. Services and other requirements to receive payment, and payment terms, are established at the beginning of the contract and renegotiated only in accordance with pre-established parameters and timeframes.

b. Contracted providers providing services in accordance with contractual requirements do not bear financial risk of late payment.

1. Payments to providers adhere to agreed-upon timeframes.

c. Payment mechanisms maximize federal dollars for the State of Connecticut.

5. REPORTING AND MONITORING: Reporting and monitoring promote efficiency and accountability.

a. Reporting and monitoring systems emphasize the level and efficacy of services for consumers.

1. Providers and government agree in advance and adhere to evaluation methods, which may include assessments by staff and consumers as well as other performance measures.
2. Providers and government agree in advance to program activity measures that provide pertinent information about the services.

b. Reporting, billing, and monitoring systems are efficient and standardized across services and government agencies.

1. Reporting requirements are scaled to the amount of funding provided.
2. Compliance requirements related to financial management are consistent with generally accepted accounting standards.
3. Government monitoring procedures for financial and organizational compliance are standardized and accepted across government agencies, with the objectives to reduce paperwork and eliminate redundant monitoring.

c. Technology efficiently serves the information needs of government and service providers, including the input, reporting, and analysis of service and billing information.

1. Government agencies use common systems for provider reporting and billing to avoid duplicate entry.
2. Government reporting systems allow providers to access the data that they have reported to the government.
3. Government reporting systems allow interface with provider information systems, including furnishing an electronic document vault/file cabinet.
4. Government invests in current technology including its own systems, systems that government requires providers to use, and the related costs of providers' systems.

d. Providers and government agree on the best techniques to demonstrate value of services and prudent use of public funds.

6. COMMUNICATION: Open communication and mutual accountability are critical for government and nonprofit providers to fulfill their shared commitment to the public good.
    a. Government and providers are proactive and responsive in their communications concerning all aspects of the contracting relationship, including opportunities and challenges.
        1. Government seeks input from providers about potential contract changes and requirements, as well as realistic timeframes to implement these activities.
        2. Government provides information about contract changes, requirements, and deadlines within reasonable timeframes to provide for thoughtful planning and to minimize negative consequences for consumers.
        3. Government engages providers in developing and implementing quality standards, outcome measurements, and reporting and billing systems.
        4. Specific individuals within the government and provider structures are designated as contacts for the other party for problem solving and other communication.
        5. In addition to informal communication, there are specific mechanisms that provide opportunities for regular dialogue between government and providers.
            b. Government coordinates human services contracting activities across departments and agencies in order to enhance efficiency and effective service delivery for consumers.
            c. Government regularly makes information on human services and their results available to the public. (2)

(1) Adapted from: State of Connecticut: Commission on Nonprofit Health and Human Services (2011) Final Report, Special Act 10-5 (pp 79)

(2) Adapted from: Fair and Accountable Principles for a Sustainable Human Service System (Chicago, IL: Donors Forum, January 2010)

APPENDIX B

Recommended Cross-Agency Population Results Statements,

Indicators of Success and Data Development Agendas

Population Result Statement:

All Connecticut residents live in safe families and communities.

Indicators are intended to be disaggregated at various levels, where appropriate and available (e.g. race/ethnicity, socioeconomic status, disability, geography, age).

Headline Indicators

1. Per Capita Crime Rate (disaggregated by juveniles, violent and property) (Dept. of Emergency Management and Homeland Security)

2. Arrests for Domestic Violence (Source: CT Judicial Branch)

2. Substantiated cases of abuse and neglect – Child and Elder (Sources: Depts. of Children and Families and Social Services, Office of Protection and Advocacy)

3. Traffic accident resulting in injury or death per capita (Dept. of Emergency Management and Homeland Security)

5. School Safety (Youth Risk Behavior Survey)

Secondary Indicators

1. Percent of Infrastructure that are unsafe (bridges, roads, "blight") (Source: Department of Transportation)

2. Per capita injury or deaths resulting from fires (Dept. of Emergency Management and Homeland Security)

3. Percent of Communities with Updated Emergency Preparedness Plans (Dept. of Emergency Services and Public Protection)

4. Number of Workplace Accidents/Violence (Source: OSHA)

5. Rate of recidivism (Department of Emergency Management and Homeland Security – Annual Arrests Data)

Data Development Agenda:

1. CT Crime Victimization Rates
2. CT Citizen perception of safety
3. Average emergency/rescue response time

Population Result Statement:

All Connecticut residents are economically secure.

Indicators are intended to be disaggregated at various levels, where appropriate and available (e.g. race/ethnicity, socioeconomic status, disability, geography, age).

Headline Indicators

1. Unemployment rate for > 6 months and 12 months (DOL)
2. Percent of population with income less than the 200% of Federal Poverty Level (Broken out by age group (youth, adults and seniors) (U.S. Census)
3. Percent of all households receiving SNAP (Supplemental Nutrition Assistance Program) (DSS)
4. Percent of households paying more than 30% and 50% of income towards housing costs (U.S. Census)
5. Percent of adults with post-secondary education (U. S. Census)

Secondary Indicators

1. Percent of adults with at least a high school diploma (U.S. Census)
2. Percent new workers retained in employment for 6 months and12 months (DOL)
3. Percent of working age residents with affordable child care (DSS)
4. Percent of children with no parent with full-time, year round employment (DOL)
5. Number of jobs by wage level (DOL)
6. Number of residents who are homeless (CT Coalition to End Homelessness Point in Time Count)

Data Development Agenda:

1. Determine factors relating to an individual's ability to work such as disabilities, educational status, etc.
2. Percent of underemployed getting full-time employment beyond Unemployment Insurance limits
3. Percent of households/families with savings/assets
4. Percent of CT residents with reliable transportation
5. Number of CT residents whose citizenship or resident status is undocumented
6. Rate/amount of student loan debt of CT residents.

Population Result Statement:

All Connecticut residents are developmentally, physically, and mentally healthy across the life span.

Indicators are intended to be disaggregated at various levels, where appropriate and available (e.g. race/ethnicity, socioeconomic status, disability, geography, age).

Headline Indicators

1. Percent of CT residents without health insurance.(DOI)
2. Premature mortality (all causes) up to age 75 or percent of CT residents who live to age 75.
3. Percent of youth/adults who report mental health as not being good (i.e. stress, depression, and problems with emotions) during the past 30 days. (DMHAS, Youth Risk Behavior Surveillance Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS)
4. Percent of children born with low/very low birth weight (DPH)
5. Percent of CT residents who are obese (BRFSS) and (YRBS)

Secondary Indicators

1. Mortality rates for the top three causes of death in CT (DPH Mortality data)
2. Percent of adults who lost more than 6 teeth (BRFSS)
3. Percent of children who received Birth to Three (early intervention) services who did not require preschool special education services. (DDS, DOE)
4. Percent of youth/adults who reported having an addiction. (YRBS) (BRFSS) (DMHAS)
5. Number of days the Air Quality Index exceeds 100 (DEEP)
6. Percent of CT residents who smoke. (BRFSS) (YRBS)

Data Development Agenda:

1. Mortality rates by cause, race and ethnicity
2. Percent of CT residents that have a medical home.
3. Oral health for adults
4. Routine prescription medication adherence.

Population Result Statement:

All Connecticut residents succeed in education and are prepared for careers, citizenship and life.

Indicators are intended to be disaggregated at various levels, where appropriate and available (e.g. race/ethnicity, socioeconomic status, disability, geography, age).

Headline Indicators

1. Percent of Entering Kindergarteners Needing Substantial Instructional Support (SDE)
2. Percent of 3rd graders at or above Goal on CMT Reading and Math (SDE)
3. Cohort High School Graduation Rate (SDE)
4. Percent of 16-24 year olds employed, in school, or in the military (US Census Bureau)
5. Percent of population age 25-34 with a college degree (US Census Bureau)

Secondary Indicators

1. College graduation rate for Connecticut colleges and universities (Board of Regents?)
2. Chronic absenteeism – Percent of students with absences of 10% or greater when compared to the total number of days enrolled in the school year (SDE)
3. Percent of 8th graders at or above Goal on CMT Reading and Math (SDE)
4. Percent of CT Technical High School graduates eligible for National or State Certification /Licensing Credential (Source: SDE)
5. Percent of Connecticut residents without a high school diploma who are enrolled in adult education programs. (Source: SDE and U.S. Census Bureau)
6. Percent of adults registered to vote (Secretary of the State)
7. Percent of registered voters who vote in elections (Secretary of the State)

Data Development Agenda:

1. Percent with Vocational/Certificate/Professional Licensure program completion (Source: ???)
2. Percent of kindergarteners with pre-K experience (Source: SDE)
3. Percent with summer reading loss (Source: SDE)
4. Naturalization rates by state (Source: USCIS)
5. Graduation rates for teen parents

Population Result Statement:

All Connecticut residents who are elderly (65 +) or have disabilities live engaged lives in supportive environments of their choosing.

Indicators are intended to be disaggregated at various levels, where appropriate and available (e.g. race/ethnicity, socioeconomic status, disability, geography, age).

Headline Indicators

1. Percent of employed CT residents who are elderly (65 +) or have disabilities. (Employment Rate - http://www1.ctdol.state.ct.us/lmi/laus/default.asp)
2. Percent of CT residents who are elderly (65 +) or have disabilities and are engaged in volunteerism or other community activities. (DDS; data development for other populations; Area Agencies on Aging)
3. Percent of CT residents who are elderly (65 +) or have disabilities and receive care in a home based/ community setting vs. an institutional setting. (DDS, DMHAS, DCF, DSS, Commission on Aging)
4. Substantiated cases of abuse and neglect. (DDS, Office of Protection and Advocacy, DSS, DMHAS – Data Development for other populations)
5. High School and Post-Secondary Graduation Rates – disaggregated by disabling conditions. (SDE/ConnCan/Other Sources (http://ctmirror.org/story/14927/expected-graduation-rates-drop-drastically)

Secondary Indicators

1. Percent of CT residents who are elderly (65 +) or have disabilities with depression. (DMHAS – self-reported survey)
2. Percent of CT residents who are elderly (65 +) or have disabilities living in poverty (DSS)
3. Substantiated cases of discrimination based on age/disability. (Commission on Human Rights and Opportunities)
4. Number of crimes against persons based on age/disability. (Judicial Branch)
5. Percent of CT residents who are elderly (65 +) or have disabilities that are homeless or at risk of becoming homeless. (DSS; AAAs; Commission on Aging)

Data Development Agenda:

1. Community Engagement Data (non-DDS)
2. Substantiated cases of abuse and neglect (Other vulnerable populations not included above)
3. Institutional v. Home-Based Care
4. Caregiver data

Population Results Statement:

All children grow up in a stable environment, safe, health and ready to succeed.

(From: CT Kids Scorecard)

Headline Indicators

1. SAFE –
   a. Referrals to Juvenile Court for Delinquency
   b. Total Substantiated Cases of Abuse and Neglect - rate per 1,000 children: all age ranges
   c. Fatalities: all causes, age 0 - 18
   d. Rate of Childhood ER Visits for Injuries of All Causes per 100,000: 0-4 y/o
   e. Rate of Childhood ER Visits for Injuries of All Causes per 100,000: 5-14 y/o
   f. Rate of Childhood ER Visits for Injuries of All Causes per 100,000: 15-19 y/o
2. STABLE -
   a. Percent of Chronic Absenteeism Percent of children living in families where no parent that has full time, year-round employment
   b. Percent of renters who spend more than 30% of their income on housing
   c. Percent of families who report not having enough $ in the past 12 months to buy food for self or family

3. HEALTHY –
   a. Rate of Singleton Low Birth Weight (per 100 births)
   b. Prevalence of Childhood Obesity, per 100
   c. Percentage of children who have health insurance

4. FUTURE SUCCESS –
   a. Cohort High School Graduation Rate
   b. Percent of 3rd graders at or above goal in Reading (CMT)
   c. Percent of Children under 18 Living in Households under 100% of the Federal Poverty Line
   d. Percent of Entering Kindergartners Needing Substantial Instructional Support

Secondary Indicators

1. SAFE –
   a. Safe Environments: Percent of H.S. Students who missed at least one of the last 30 days of school because they felt they would be unsafe at school or on the way to or from school
   b. Emergency Room Visits for Traumatic Brain Injury Cases (Rate per 1,000 children)
2. STABLE -
   a. Kids in out-of-home placements (Rate per 1000)
   b. Percent of single parent households
   c. Percent of children eligible for free/reduced lunch
   d. Rate of SNAP participation - by recipients (rate per 1000)
   e. Percent of Homeowners who spend more than 30% of income on housing
   f. Percentage of High School students who ate at least one meal with their family on three or more of the last seven days
   g. Percentage of High School students who agree or strongly agree that their family loves them and gives them help and support when they need it

3. HEALTHY –
    a. Percent of Age-appropriate Immunizations for Children Two Years Old
    b. Rate of Asthma-Related Childhood visits to the Emergency Department, per 10,000
    c. Prevalence of Childhood Asthma, per 100 (weighted percent)
    d. Percentage of Students Seriously Considered Suicide in past 12 months

4. FUTURE SUCCESS –
    a. Percent of Kindergartners previously enrolled in pre-school
    b. Percent of population age 25-34 with at least an Associates Degree
    c. Percent of 16-24 year olds employed or in school
    d. Percent of 8th Graders at or above goal in Reading (CMT)
    e. Percent of 8th graders at or above goal in Math (CMT)
    f. Percent of 3rd Graders at or above goal in Math (CMT)
    g. Percent of Live Births in Connecticut to Mothers Less than 20 Years of Age

Data Development Agenda:

1. STABLE -
    a. Rate of Family Homelessness
    b. Rate of School Transiency
    c. Rate of Domestic Violence
    d. Rate of Incarcerated Parents
    e. Percentage of children living in household with a Teen Parent

2. FUTURE SUCCESS –
    a. Percent with Vocational/Certificate/Professional Licensure program completion
    b. Percent of infants/toddlers who are achieving developmental milestones
    c. Percent of infants/toddlers identified for services who are receiving services
    d. Youth Unemployment

APPENDIX C

REQUEST-FOR-PROPOSAL and

PROCUREMENT PROCEDURES

Working Group's

Final Report to

The Governor's Cabinet on
Nonprofit Health and Human Services

June 29, 2012

RFP and Procurement Processes Working Group Members

Co-chair Chris Andresen, Connecticut Department of Public Health

Co-chair Anne Ruwet, CEO, CCARC, Inc.

Jewel Brown, Executive Director, North Star Center for Human Development

Cheryl Cepelak, Deputy Commissioner, Department of Correction

Roberta Cook, President & CEO, Harbor Health Services

Alyssa Goduti, Vice-President of Business Development and Communications, Community Health Resources (CHR)

Judi Jordan, Department of Children and Families

Barry Kasdan, President, Bridges...A Community Support System, Inc.

Daniel J. O'Connell, Ed.D., President & CEO, Connecticut Council of Family Service Agencies

Rick Porth, President and CEO, United Way of CT, Inc./2-1-1

Walt Sivigny, DMHAS

Working Group Charge

1. Review RFP and procurement process and how they can be used to incentivize strategic partnerships

2. To look at appropriate use and timing of competitively bidding contracts and how that will affect program outcomes and innovative programming

Background

- **Meetings**

  The RFP and Procurement Processes Workgroup (workgroup) met six times between December 2011 and May 2012.

- **Organization of Working Group**

  The workgroup included two subcommittees that each focused on one of the components of the group's charge, and met outside of the monthly workgroup meetings to draft the major components of this report. The strategic partnership subcommittee consisted of co-chair Anne Ruwet, Richard Porth, Deputy Commissioner Cheryl Cepelak, Daniel O'Connell, Jewel Brown, and Tammy Freeberg. The procurement standards subcommittee consisted of co-chair Chris Andresen, Alyssa Goduti, Judi Jordan, and Roberta Cook.

The workgroup benefitted from the attendance and participation of non-workgroup members including Liza Andrews, Project Director from the Connecticut Nonprofit Human Services Cabinet and Tammy Freeberg, Director of Grants and Program Development from the Village for Families and Children.

- **Presentations, guest speakers, technical assistance**

  Sabrina Trocchi, DMHAS Chief of Staff, attended the February workgroup meeting to discuss DMHAS's practice improvement initiative

  Patrick Johnson, President, Oak Hill, contributed to the language used to describe partnerships in the introduction to the section on partnership principles

  Staff from the Department of Public Health AIDS & Chronic Diseases Section coordinated workgroup activities (minutes, notifications, meeting logistics, etc), and the procurement standards subcommittee.

  Connecticut Council of Family Service Agencies coordinated the activities of the strategic partnership subcommittee.

- **Data, Information, Studies, etc. used to support findings, recommendations and conclusions.**

  Fair and Accountable: Partnership Principles for a Sustainable Human Services System (Chicago, IL: Donors Forum, January 2010)

  State of Connecticut: Commission on Nonprofit Health and Human Services (2011) *Final Report, Special Act 10-5*

  Centers for Disease Control and Prevention 2003–2008 HIV Prevention Community Planning Guidance

Findings

The workgroup found that the procurement standards included many mechanisms for flexibility with regards to Purchase of Services (POS) contracts including some meaningful rationales for considerations of waiver from competitive bidding. However the group felt there are other rationales that should be included. The group also felt that the procurement schedule required of all agencies may not always maximize benefits for clients that receive services through POS contracts.

The workgroup recognizes that a healthy private nonprofit sector is vital to the well-being of the citizens of Connecticut. Nonprofit Health and Human Service providers and state government must work collaboratively as partners to assure the provision of high quality, essential services to Connecticut's most vulnerable citizens. The workgroup adapted partnership principles that it feels will help facilitate a true partnership that can assist all of us to fully embrace and utilize established results based accountability practices to demonstrate meaningful and appropriate outcomes for all state funded programs.

Recommendations

The following are comments and recommendations related to the current OPM procurement standards. The workgroup reached consensus on all recommendations

2. Applicability:
   Page 4 references applicability to the Executive Branch agencies. The Judicial Department holds a large number of contracts with POS agencies. We understand that Judicial is not held to these standards as a separate branch of government. However, the procurement standards include many best practices and improve consistency of contracting. We suggest that Judicial be invited to utilize the same standards.

3. Training:
   Page 6, H.3. – We recommend that all agencies utilize standard training for all staff with procurement responsibilities. We suggest investigating web-based training to reduce costs and improve efficiencies. Agencies may provide additional materials to address agency-specific policies and procedures.

4. Sole Source Contracts:
   Page 8. We recommend changing the criteria required for waivers. We suggest changing "When a state agency wishes to make a sole source procurement and the anticipated cost or term of the contracts exceeds $20,000 (change to $50,000) or exceeds one year (change to 2 years), the agency must request a waiver from competitive solicitation …." Increasing the dollar limit and length of contract allowed for sole source contracting saves time and resources for both the state and providers.

5. Waivers from Re-Procurement:
   Page 9. We recommend revisiting the factors identified as considerations for a waiver to include things such as evidence-based models which require significant investment at the provider level. The list of considerations in the procurement standards should be consistent with the options available to state agencies in the forms used to request waivers.

6. Procurement Schedule:
   Page 12. This section lists "the level of satisfaction or dissatisfaction with a current contractor's performance" as a factor to determine re-procurement. We encourage the state to use the contract monitoring and oversight systems to address poor performing providers. If a particular area of service needs to be rebid due to underperformance, we encourage state agencies to only rebid that particular geographic service area and not do a statewide re-procurement.

7. Evaluating the Need:
   Page 15. We recommend amending this section, to more concisely and clearly describe when a state agency should engage a contractor. Recommended new language is below:

   Before entering into a contract, an agency must first evaluate the need to do so. If an agency's existing employees lack the necessary expertise, or are already fully committed to other responsibilities, a state agency may choose to purchase services through a contract. An agency should also consider whether another State agency has the resources to provide the service, or whether it is possible to purchase it on a cooperative basis with other State agencies.

State agencies should consider the following factors when determining if they should engage a contractor: (1) the need for outside expertise, (2) the lack of internal resources, or (3) the need for independent judgment or objectivity. In terms of expertise, a contractor can provide special skills or knowledge that an agency's regular, full-time employees do not possess. In terms of resources, a contractor can provide a needed service without diverting the efforts of regular employees who may be already committed to other responsibilities. In terms of objectivity, a contractor can provide an unbiased view of an agency's operations, identify problem areas, or suggest improvements. (add a note - this section relates to PSAs, Not POS Contracts)

8. Writing the RFP:
   Page 20. Procurement should have a foundation based on an overall planning process. State agencies should develop forums for ongoing communication with providers on their service system design and potential changes (i.e. DCF's Continuum of Care Partnership). State agencies should have the option of a "state planning process" prior to the writing of the RFP, to utilize the expertise of stakeholders to determine models, design and program details. The state should develop a process that would result in information similar to that gathered from a Request for Information, but would be less formal and arduous for providers. A state agency could identify a particular need and interested parties, invited through a public posting on the DAS website, could meet to discuss and recommend models to address that need.

9. Evaluation Criteria:
   Page 24. We suggest removing the second paragraph on page 24, which recommends concealing weight criteria for applicants. Weight criteria should be clearly identified in the proposal. Weight of each question is helpful to applicants in understanding priorities of the agency and is fair if revealed to all applicants.

10. Contractor Selection:
    Page 34. This section references sending the three top ranking proposals to the agency head. However there are some examples in which an agency may be selecting multiple providers. We therefore recommend that the language allow for the selection committee to submit their full recommendations for consideration to the agency head.

11. Contractor Selection and Timeline:
    Page 34. We recommend that the language be strengthened to say that contracts should be processed in a timely manner. We suggest that providers and State agencies make a good faith effort to complete contract negotiations within 45 days of notification of the winning bid.

12. Debriefing:
    Page 36. The language currently states that the debriefing must not include any comparisons of unsuccessful proposals with other proposals. We suggest that language be added to say that the debriefing is an opportunity for a provider to get feedback on their proposal. Providers will also receive feedback on how their proposal ranked in comparison with other applicants.

13. Monitoring Contractors:
    Page 37. We suggest adding a bullet to demonstrate collaboration and process improvement as a part of the contract monitoring process. The bullet may read "Collaborative discussions geared towards service delivery improvement."

14. Notification of Bid Outcomes:

We suggest that state agencies post notifications of winning proposals on their websites to improve communication and serve as a more public notice.

15. Submission of Proposals
    We recommend that state agencies accept electronic submissions of proposals whenever practical. This improves efficiency and reduces costs.

16. Technical recommendations:

    a. Increase the $20,000 threshold for sole source to $50,000 which requires a statutory change.

    b. Page 21. Needs to be amended to recognize that OPM has developed a standard RFP template.

    c. Take out "Screening Committee" on page 24 and 25. The Screening Committees don't typically review rating sheets prior to an RFP release.

    d. Remove the second sentence in the definition of "End Users." It is inaccurate.

Principles to Guide the State-Private Nonprofit Provider Partnership

Introduction

The workgroup endorses the principle that a healthy nonprofit health and human service provider system is vital to the well being of the citizens of Connecticut. Nonprofit human service providers act as stewards of the state in meeting essential functions of government, caring for the most vulnerable residents. In meeting this joint mission, partnerships exist on multiple levels.

Nonprofit agencies are governed by volunteer Boards of Directors made up of diverse representation from the community served, acting as policy makers with fiduciary responsibility for the nonprofit agency. Along with this comes an army of volunteers and charitable dollars and other in-kind support. Businesses and individual donors support this mission through their philanthropic giving. Municipalities support the work of their local nonprofit organizations through collaboration with their local services. Through these roles, the community gathers to work together in partnership to maintain the safety net. Historically virtually all of human services were delivered through these nonprofit mediating institutions. The presence of government made it the responsibility of the whole civil society to fund and support this work. Government, like our nonprofit agencies is responsible to the community and must hold community providers and itself accountable for the prudent and appropriate us of the scarce resources it is charged with administering. Ultimately state agencies and the legislature partner with nonprofits to effectively and efficiently meet the needs of citizens. It is essential that this vital partnership be strengthened and supported to assure that the safety net is preserved and the most vulnerable among us are treated with dignity, respect, and quality of life sustaining services as well as opportunities to overcome whatever their challenges.

The nature of health and human services that are provided by nonprofits is fundamentally different from other state contracted services and requires increased state agency discretion and flexibility in procurement, contracting and monitoring. It is important that the state provide a system of procurement and adequate funding to support the optimal provision of these unique services now and in the future. Nonprofit health and human service providers must be recognized as critical partners with state government in the provision of high quality, essential services to Connecticut's most vulnerable citizens. The state's procurement, contracting, payment and quality assurance systems should provide appropriate, meaningful and ongoing opportunities for state agencies and nonprofit providers to collaborate and partner in implementing evidence-based, outcomes-driven and financially sustainable service delivery systems. It is imperative that the nonprofit provider community fully embrace and utilize established results based accountability practices to demonstrate meaningful and appropriate outcomes for all state funded programs. This can only be achieved by working together in a true partnership.

The following key areas for Guiding Partnership Principles are intended to promote a fair, effective, responsive, transparent and accountable partnership between nonprofit providers and their state government funders.(1) The workgroup reached consensus on these principles.

(NOTE: The full detailed Principles appear in Appendix A of this report.)

I. CONTRACTED SERVICES: All contracted services are based on a dynamic, data-driven system.

A. Contracted services are based on a comprehensive and transparent planning process that defines and prioritizes services.

B. Contracted services balance best practices and good stewardship of public dollars with given resources.

II. CONTRACTED PROVIDERS: The selection processes for contracted providers are transparent and competency-based.

A. The procurement for human services is a transparent and streamlined decision-making process.

B. Contracts are awarded to providers that best demonstrate an ability to achieve desired outcomes through delivery of quality services.

III. CONTRACT TERMS AND RENEWALS: Contract terms and renewals are based on community best interest and performance.

A. Contract renewal is based on provider performance and demonstration of continued ability to deliver contracted services.

B. Decisions to conduct open bidding processes rather than contract renewals consider investments required to apply for, start up, deliver, administer, and evaluate services as well as impact on existing clients.

C. When contracts are not renewed, the transition process takes the best interests of consumers and communities into account.

IV. CONTRACT AMOUNTS AND TIMELY PAYMENTS: Contract amounts and timely payments are critical to maintaining a viable system.

A. Payment is based on the full cost of efficient service delivery consistent with agreed-upon quality standards.

B. Contracted providers providing services in accordance with contractual requirements do not bear financial risk of late payment.

C. Payment mechanisms maximize federal dollars for the State of Connecticut.

V. REPORTING AND MONITORING: Reporting and monitoring promote efficiency and accountability.

A. Reporting and monitoring systems emphasize the level and efficacy of services for consumers.

B. Reporting, billing, and monitoring systems are efficient and standardized across services and government agencies.

C. Technology efficiently serves the information needs of government and service providers, including the input, reporting, and analysis of service and billing information.

D. Providers and government agree on the best techniques to demonstrate value of services and prudent use of public funds.

VI. COMMUNICATION: Open communication and mutual accountability are critical for government and nonprofit providers to fulfill their shared commitment to the public good.

A. Government and providers are proactive and responsive in their communications concerning all aspects of the contracting relationship, including opportunities and challenges.

B. Government coordinates human services contracting activities across departments and agencies in order to enhance efficiency and effective service delivery for consumers.

C. Government regularly makes information on human services and their results available to the public. (2)

1. *Adapted from: State of Connecticut: Commission on Nonprofit Health and Human Services (2011) Final Report, Special Act 10-5 (pp 79)*

2. *Adapted from: Fair and Accountable Principles for a Sustainable Human Service System (Chicago, IL: Donors Forum, January 2010)*

Next Steps:

This workgroup recommends that the Cabinet accept these recommendations and incorporate them into their final report. We recognize that some of these changes require statutory change.

We recommend that a workgroup of the Cabinet be designated to operationalize the partnership principles. They would be charged with developing concrete steps to help implement these principles within state agencies and the nonprofit human service system.

Conclusion:

The workgroup appreciates the opportunity to convene State agencies and nonprofit organizations to discuss RFP and procurement process for Purchase of Services. We have concluded that recommendations in this report can improve the competitive bidding process and promote stronger strategic partnerships between the State and nonprofit organizations that will ultimately improve outcomes for the clients we collectively serve and make innovative programming more feasible.

APPENDIX D

RATE SETTING Working Group's

Final Report to

The Governor's Cabinet on Nonprofit Health and Human Services

August 15, 2012

RATE METHODOLOGIES WORK GROUP

List of Members: Scott McWilliams (co-chair) DMHAS Budget Director; Patrick Johnson Jr. (co-chair), President, Oak Hill; Barry Simon, CEO Gilead Community Services; Barbara Lanza, Program Manager, Court Support Services, Judicial Dept.; Chris La Vigne, DSS Director of Contract and Rate Setting; Joel R. Ide, DOC, FAMI; Cindy Butterfield, DCF Finance Director; Glenn Connan, MCCA Vice President & CFO; Joseph Drexler, DDS Deputy Commissioner; Judy Dowd, Health & Human Services Section Director, OPM; Robert Dakers, Executive Finance Office, OPM; Deborah Chernoff, Communications Director District 1199 SEIU; (Frank McCarthy CEO of Marrakech Inc. attended and contributed regularly as a representative of the public.)

Workgroup Charge: Address how payment rates to providers are determined by the agencies and make suggestions for standardizing the methodology where appropriate. Examine how the methods of setting rates reflect / do not reflect the costs involved with providing services and how that can be improved.

Background: The workgroup met ten times in the Finance Office Conference Room at Haviland Hall CT Valley Hospital. The co-chairpersons met with Dr. David Garvey from the UConn Nonprofit Leadership Center to review access to data on the Urban Institute platform derived from the IRS 990 form submitted annually by all 501-C-3 nonprofit organizations in CT. Staff at the Urban Institute was also consulted regarding technical issues with the data site. The Urban Institute National Study of Nonprofit Government Contracting was also consulted and their CT summary is attached.

The 2010 *Fair and Accountable Partnership Principles for a Sustainable Humans Service System* by the Donor's Forum from Chicago, Illinois was also utilized as a conceptual framework for our deliberations.

In addition a questionnaire was distributed to the CT Nonprofit Human Service Cabinet and through them to the various trade associations representing nonprofit human service providers in the state, principle among them the CT Association of Nonprofits and the CT Community Providers Association. A small sub-committee of our work group, chaired by Marcie Dimenstein, compiled and analyzed the responses to the questionnaire. A chart made available by the CT Community Providers Association was also utilized and tracks cost of living adjustments to state contracts since 1987. In addition Mr. Robert Dakers, of the Office of Policy and Management, made available data on a random sample of nonprofit organizations (the same sample used in 2011 by the Commission on Nonprofit Health and Human Services) which provides an opportunity to examine two year trend information compiled from the independent audits submitted annually by community nonprofit organizations under contract to the state.

All of the state agencies contracting for human services provided information about their cost determination and rate setting methodologies and this information was compared and contrasted by the workgroup and a summary is attached.

Because the question was raised about cuts to health care benefits by community nonprofit organizations in order to cope with the recession, the workgroup attempted to gathered data on the numbers of employees of nonprofit organizations currently enrolled in HUSKY A,B, & C state health plans. Because of technical problems with the DSS computer system we were unable to obtain the

necessary data in time for analysis by our workgroup in spite of a great effort by DSS staff. This data would be well worth pursuing for future study.

The CT Nonprofit Human Service Cabinet (an association of Nonprofit Associations) circulated among its members a questionnaire exploring the impact of flat funding in recent years combined with underfunding preceding that. With many responses, principal among them from CT Non Profits Inc. and The Connecticut Community Providers Association, the information provided was most helpful in composing our recommendations and stimulated lively discussions at our meetings.

The workgroup also reviewed the 2011 work of the Commission on Nonprofit Health and Human Services and recommendations from that group were considered for inclusion in the workgroup's report.

INTRODUCTION:

Maintaining a viable private community nonprofit human service system in Connecticut is essential to the quality of life, productivity and economic vitality of our state and its families and essential to the public private partnership that has been the foundation stone of human services in Connecticut for centuries. Without the community nonprofit health and humans service providers there would be no efficient effective delivery system for essential services. Families and their loved ones depend on this system for, to name some but not all, behavioral health services, disability services, substance abuse services, homeless shelters and community based corrections. When all is said and done in the nonprofit world the singular focus is on mission and when the mission is not accomplished people suffer. Usually those who would suffer are among the most vulnerable.

In addition the nonprofit system is a major employer of all levels of employment and has a significant economic multiplier effect that impacts local communities and state tax revenue. To quote the Fair and Accountable Partnership Principles for a Sustainable Human Service System; "Timely payments at sufficient amounts for quality service delivery is critical to an effective system that meets consumer's timely needs. Nonprofit human service providers face rising costs and are required to provide the same or higher levels of service, incorporate higher quality standards, and carry out unfunded mandates – all with funding that does not increase at a rate to match these demands. At the same time government faces a structural deficit and cash flow constraints which create chronic shortfalls in revenue that are passed along to the service providers. The cumulative impact over a number of years has been to weaken the human service infrastructure…" In keeping with our public private partnership and in the interest of assuring the viability of the community nonprofit sector it is essential that contracted rates and fees for service be based on the full cost of efficient service delivery consistent with agreed upon quality standards and payment made in agreed upon timeframes.

FINDINGS:

The evident consistent pattern of underfunding with less than 1% per year on average for over 20 years, (see chart from Connecticut Community Providers Association) of community based nonprofit providers of health and human services in CT continues to leave the majority of these providers of vital services in a weakened and in some cases precarious financial position, with only 34.95% in the sample of 2010 audits reviewed having the recommended operating reserve ratio of 25% or more,

with 19.8% being below 10% and 15.1% below zero. In its 2009 national study of nonprofit contracting, **Urban Institute data ranks Connecticut as the 7th worse state in the nation when it comes to state contracts covering the full cost of contracted services. In addition, 73% of nonprofit agencies in CT with budgets of $1 million or more are in deficit compared with 40% nationally in 2009.** (**According to the audit sample data for 2010 a reported deficit occurred in 43% of the data**). The trend from 2009 to 2010 in general is not encouraging. The number of nonprofit agencies not meeting acceptable operating reserves grew from 60.39% in 2009 to 67.44% in 2010. These overall poor results indicate that more providers are experiencing chronic cash shortages. **The debt ratio also increased from 54.54% to 57.95% from 2009 to 2010 making providers less attractive for financing opportunities. 66.27% of all providers current liquidity ratio indicates that they would have difficulty meeting their short term obligations.**

The workgroup also examined ten years of trend data with almost 300 providers in the sample supplied by the Urban Institute utilizing some of the same ratio analysis for financial stability that we applied to the audit data. The Urban Institute data is based on annual 990 form filings done by all 501-C-3 corporations for the IRS who meet the reporting requirements. **Trend data indicates a deterioration of financial stability over the ten year time frame. For example the Savings Indicator average in 2000 was 5% on average. In 2010 it had dropped to 2%. The percentage of providers with substandard ratings increased from 55% to 72%. Thus they are in danger of going out of business with any event that causes a financial reversal. The Surplus Margin Ratio in 2000 was 3% with 55% of all providers having a substandard score. In 2010 the average score had dropped to 1% with 72% of all providers having a substandard score. Thus, with an average surplus margin of 1% there is little or no opportunity for reinvestment or ability to establish a safety net.**

The combination of increasing fixed costs such as utilities, rent, employee benefits, fuel, etc while state reimbursement remains flat is the major contributor to these ratios and fiscal challenges. Many providers have indicated that they have responded to these fiscal issues through reduced benefits, flat wages for employees and neglect of infrastructure while spending down reserves. It is particularly problematic for their lower paid direct care employees. The work is physically and emotionally taxing and these personal care attendants, child care workers, group home workers, nursing assistants, etc. face similar financial challenges as the people they serve. The vast majority are women. The work group is seeking information related to how many private provider workers are qualifying for public assistance such as Husky Health plans, Medicaid, and food stamps due to low income. In addition many are reportedly working part time with few or no benefits and are working multiple jobs, oftentimes creating the potential for unsafe conditions due to lack of sleep. Since wages and benefits constitute 70% to 80% of operating budgets in private community nonprofit service providers, they face a Sophie's choice. Cost reductions to balance budgets must come from wages and benefits or cut programs to maintain services and assure fiscal viability.

Also, some state agencies do not pay contractors in a timely manner consistent with agreed upon timeframes and thereby create additional hardships and costs of borrowing for nonprofit service providers. The Urban Institute data indicates 43% of nonprofits in CT report late payments. This compares with 41% national average. An additional serious concern is the neglect of infrastructure as physical plants are neglected to keep budgets in balance. Thus roofs, mechanical systems, and basic maintenance are extended beyond prudent limits.

It is important to recognize that community nonprofit human service providers are charitable organizations recognized by the Federal Government as 501-C-3 agencies exempt from taxation and governed by volunteer boards of directors made up of local residents representative of the communities within which they are based. These boards and the donors they cultivate contribute significant private charitable dollars and untold volunteer hours to supplement the quality and extent of care in addition to state revenue. From a historical perspective, to contract with community nonprofit human service providers is, in reality, to contract with and reinvest in the community itself in the interest of the common good. It is neither reasonable nor possible for private charity to supplant the state's responsibility with respect to caring for its most vulnerable citizens.

STATISTICAL FINDINGS AND TRENDS

Ratio Analysis Eleven Year Trend

In effort to assess the impact of the financial environment on the Non Profit Provider Community and how this has impacted operations, the Committee performed an analysis of financial ratios over the 11 year period of 2000 to 2010. The Committee felt exploring results of long term trend data analysis was important because of the reaction to last year's report from the Commission on Nonprofit Health and Human Services, Private Provider Cost Increases, Nonprofit Agency Financial Condition and Sources of Revenue Workgroup Report**.** The report included the previous year's financial ratios for a statistically sound representation of 101 providers. The ratios painted an unfavorable picture of the financial health of the Private Nonprofit operations that indicated that the Private Nonprofits were working very close to the margin.

The reaction to these findings was that there is a belief that most providers have regularly functioned very close to the financial margin and this was business as usual. The Providers indicated they found themselves becoming increasingly financially unstable and were concerned about their ability to continue to provide quality services in a safe environment. Although many providers over the years have struggled to remain in the black and provide a quality service, events in the past several years has caused many new providers and become part of the majority of providers that have poor financial indicator scores.

The goal of this 11 year span analysis is to provide a concrete analysis of the financial position of the provider community and it will allow a determination to be made if the current financial status is business as usual or if Providers are actually operating in a declining environment that is unprecedented. The following are the results of this analysis:

Leverage Ratio

The Leverage Ratio is financial ratio that calculates an organizations end of year liabilities over the end of year assets. (EOY Liabilities/EOY Assets).

During the 11 year span the providers have seen a significant change in their financial position. In 2000, 42% of all providers had a substandard rating. In 2005, the ratio experienced a jump with 46% of providers having a substandard score and in 2010, 51% of all providers had a substandard rating. The average score in 2000 amongst all providers was 53%, while the score increased to 62% in 2010. These results not only indicate that 9% more providers find themselves with a substandard

leverage score, carrying too many liabilities for their level of assets but also, the providers on average have scores that are 15% worse than they were 11 years ago.

Although there was an increase in the score in 2005 there had been a recovery in subsequent years. Beginning in 2008, the scores steadily worsened and were at their worst in the last year of the analysis in 2010. The years where providers showed sharp declines in their financial health were preceded by a year with no cost of living increase.

Savings Indicator

The Savings Indicator demonstrates an organization's ability to save funds to reinvest in programming and withstand any potential emergency situations that might arise and financially threaten an organization's operations. (Net Income/Total Expenses)

In 2000, the average savings indicator over the provider network was 5%. In 2010, the average savings indicator has dropped to 2%. This is a dramatic loss in an organizations ability to react to new expectations in doing business, service development and the ability to withstand a disastrous event. During the same period of time the percentage of providers with substandard ratings increased from 55% to 72%. Clearly the vast majority of all providers no longer has the funds available to adapt to meet the new service landscape and may not recover from an incident that causes a financial reversal.

The Savings Indicator reached its lowest level in 2004 with a reported high number of providers with substandard scores. These scores were likely impacted by 2004 being a year without a cost of living increase. Since providers received COLAs from 2005 to 2008, this ratio improved during this time. At the end of the 11 year period in 2009 and 2010, the scores once again dropped.

The lack of an ability to save coupled with a very high leverage ratio, means it is unlikely the providers will have the savings necessary to withstand an emergency and will likely not be able to borrow additional funding to cover the necessary expenses.

Surplus Margin Ratio

The Surplus Margin Ratio, measures the amount of net income over total revenue, also known as pure profit. (Net Income/Total Revenue)

In 2000 the average score was 3% with 55% of all providers having a substandard score. In 2004, the number of providers with substandard scores spiked at 71%. This percentage recovered in 2005 when the COLA was reinstituted. By 2010, the average score had dropped to 1%, with 72% of all providers having a substandard score. Similarly to the previous two ratios, the beginning a trend towards financial instability occurred in 2009 with the number of substandard scores peaking for 2009 and 2010. In 2000, there was a small ability to put aside funds for emergencies to or to reinvest in programming. By 2010, with the average surplus margin at 1% there is little or no opportunity for reinvestment or ability to establish a safety net.

Substandard Ratio: **Leverage** (EOY Liabilities/EOY Assets) **>50%**					
Year	Appropriated COLA	Providers w/ Substandard Ratios	Total Sample	Percent w/ Substandard Ratio	Average
2000	3%	114	269	42%	53%
2001	1%	101	260	39%	47%
2002	4%	125	286	44%	48%
2003	2%	129	289	45%	52%
2004	0%	126	291	43%	53%
2005	2%	134	294	46%	56%
2006	4%	135	297	45%	61%
2007	2%	122	295	41%	53%
2008	3%	134	293	46%	55%
2009	0%	141	290	49%	58%
2010	0%	140	274	51%	62%

Substandard Ratio: **Savings Indicator** (Net Income/Total Expense) **<2%**					
Year	Appropriated COLA	Providers w/ Substandard Ratios	Total Sample	Percent w/ Substandard Ratio	Average
2000	3%	147	269	55%	5%
2001	1%	142	260	55%	4%
2002	4%	177	286	62%	3%
2003	2%	197	289	68%	1%
2004	0%	205	291	70%	1%
2005	2%	198	294	67%	2%
2006	4%	191	297	64%	2%
2007	2%	184	295	62%	4%
2008	3%	183	293	62%	4%
2009	0%	207	290	71%	1%
2010	0%	196	274	72%	2%

Substandard Ratio: **Surplus Margin** (Net Income/Total Revenue) **Ratio <0**					
Year	Appropriated COLA	Providers w/ Substandard Ratios	Total Sample	Percent w/ Substandard Ratio	Average
2000	3%	147	269	55%	0.03
2001	1%	143	260	55%	0.03
2002	4%	178	286	62%	0.02
2003	2%	198	289	69%	0.00
2004	0%	206	291	71%	0.01
2005	2%	200	294	68%	0.01
2006	4%	191	297	64%	-0.01
2007	2%	186	295	63%	0.02
2008	3%	183	293	62%	0.02
2009	0%	209	290	72%	0.00
2010	0%	197	274	72%	0.01

A Year Later - Focus on SFY2009 and SFY2010 Comparisons

The Committee felt it was important to revisit the financial condition of the providers that had been selected for financial ratio testing in the Commission on Nonprofit Health and Human Services, Private Provider Cost Increases, Nonprofit Agency Financial Condition and Sources of Revenue Workgroup Report**.** The following is an excerpt from that report to explain how the sample had been selected:

"Method: The workgroup researched and selected tools to produce a comprehensive view of the financial condition of the State's nonprofit providers. The workgroup selected a sample group of 101 from the 490 Health and Human Services providers with revenues over $300,000 who receive State funds. The workgroup then proceeded with the calculation of various financial ratios specific to nonprofits to test the financial fitness of the sample group. The results from the sample group were then compared with the Urban Institute's National Study of Nonprofit-Government Contracts and Grants: Overview, from the National Study of Nonprofit-Government Contracting Survey Results (2009 Data), and found that the sample group and the Urban Institute's findings indicated similar results regarding the financial condition of the providers.

The Workgroup split the stratified sample group into three categories for analysis purposes. Group 1, as we will refer to it in our outcome analysis, is comprised of providers that had total revenue ranging from $300,000 up to $2,000,000, representing 31.68% of the total sample group or 32 agencies. Group 2 is comprised of providers with revenues from $2,000,000 up to $10,000,000, representing 36.64% of the total sample group or 37 agencies. Group 3 is the providers with total revenue over $10,000,000 representing 31.68% of the entire sample group or 32 agencies. The decision to split the groups by these dollar values was made because large clusters of vendors clustered at midpoints in each group and became more sparsely spaced towards the group break points."

As the Committee embarked on revisiting the initial sample group we found that only 86 of the original 101 providers has submitted audits for SFY10. The sample Group 1 of small providers decreased the most with N=32 in SFY09 decreasing to N=14 in SFY10.

The Committee culled from the original report the ratios that gave the clearest picture of the providers' financial position. The Committee compared the Liquid Funds Indicator, the Operating Reserves Ratio, Debt Ratio and the Current Ratio for this comparison exercise as follows:

The first financial ratio tested against the sample group was the: **Liquid Funds Indicator (LFI) = Total Net Assets - Restricted Net Assets - Fixed Assets/Average Monthly Expenses**

The liquid funds indicator determines the number of months of expenses that can be covered by existing assets, without the use of restricted funds. The benchmark for a favorable rating is a minimum of 1 month assets or a LFI score of 1 or more. This ratio has been used more often with nonprofit providers than the Defensive Ratio, because it does exclude restricted funds that may not

actually be available to cover operating expenses. Restricted funds are more common in the nonprofit environment than in the private sector in general because of restrictions set by donors and by the provider's board.

Synopsis of Results:

Although the vast majority of providers continue not to have an acceptable level of assets to cover one month of operating expenses, there was a very slight improvement in this ratio overall. The Average mean score in 2009 was .71 and it increased to 1.25 in 2010, with the median being -.84, in 2009, and it improving to -.83 in 2009.

The second financial ratio tested was the: **Operating Reserves/Annual Operating Expenses (OR)**

Operating Reserves are the portion of the unrestricted net assets that are available for use in cases of emergency to sustain financial operations, in the case of an unanticipated event of significant unbudgeted increases in operating expenses or losses in operating revenues. An acceptable minimum OR score is 25%.

Synopsis of Results:

Groups 1 and 2 both had increases in the percentage of providers that no longer met the 25% target for operating reserves. Group 3 had a very slight improvement with 71.88% of providers not meeting the target in SFY09, and 69.69% of providers not meeting the target in SFY10. Overall the percentage of providers that now no longer meet the target has increased from 60.39% to 67.44%. These overall poor results indicate that more providers are experiencing reserve shortages, and or higher expenses that have not been matched by reserve increases. Organizations with these OR scores are not in a position to engage in long range planning and opportunities, but rather are concerned with the current stability of the organization. This negatively impacts the service network.

The third financial ratio we tested was the: **Debt Ratio (DR) = Average Total Debt/Average Total Assets**

The Debt Ratio measures the proportion of assets provided by debt. High values indicate future liquidity problems or reduced capacity for future borrowing. The higher ratios indicate the risk to potential lenders and would cause lenders to need to increase their rate of return to mitigate the risk. Historically high risk borrowers have to pay higher interest rates if they can borrow at all. Providers that have to pay high interest rates or cannot borrow, can not actively compete for new types of business and are more harshly impacted by changes in the payer mix that require they invest in administrative and infrastructure changes.

If the ratio is less than 0.5, most of the provider's assets are financed through equity. If the ratio is greater than 0.5, most of the company's assets are financed through debt. Organizations with high debt/asset ratios are said to be "highly leveraged," and have low liquidity. An organization with a high debt ratio (highly leveraged) would find it difficult to continue to operate if creditors started to demand repayment of debt.

Synopsis of Results: The percentage of providers with Debt Ratios over .5, in Group 1 increased from 41.94% to 50% from 2009 to 2010. In Group 2, there was a slight decrease from 55.26% to

53.85% and in Group 3 it increased from 65.63% to 69.70%. Overall the provider community increased from 54.54% to 57.95%. A Debt Ratio over .5 makes the providers less attractive for financing opportunities. One might have expected more slippage in this ratio than actually occurred but many of the providers have reported that their lending institutions now consider state funded businesses to be higher risk businesses than they would have been considered in the past. They have not been able to secure financing, which in turn, causes their debt ratio to remain relatively the same. A high debt ratio coupled with not having a safe amount of operating reserves available puts a provider in a precarious financial position.

The fourth ratio tested was the: **Current Assets/Current Liabilities (CR)**

The current ratio is an indication of an agency's liquidity and ability to meet creditor's demands. If an agency's ratio is below 1 it will have difficulty meeting its short term obligations. A ratio of 2 is generally considered to be acceptable.

Synopsis of Results:

The Group 1 provider scores indicated that 40.63% would have difficulty meeting creditors' demands in SFY2009. This percentage increased to 71.43% in SFY10. This change has now made the once more financially stable Group 1 more in line with Groups 2 and 3. Groups 2 and 3 both had slight improvements but overall amongst the three Groups the percentage of agencies has remained steady over the two year period with approximately 66% of all providers having scores below 2, indicating they would have difficulty meeting their short term obligations.

Liquid Funds Indicator (LFI)		
Year:	*2009*	*2010*
Group 1	*N=32*	*N=14*
Median	-0.08	-0.21
Mean	0.53	0.62
% of Providers below an Acceptable Range	58%	57%
Group 2	*N=37*	*N=39*
Median	-0.08	-0.21
Mean	0.53	0.62
% of Providers below an Acceptable Range	58%	57%
Group 3	*N=32*	*N=33*
Median	-0.27	-0.84
Mean	0.53	0.78
% of Providers below an Acceptable Range	94%	85%
Combined Results	*N=101*	*N=86*
Median	-0.84	-0.83
Mean	0.71	1.25

Operating Reserves Ratio (OR)		
Year:	*2009*	*2010*
Group 1	N=32	N=14
Median	22%	14%
Mean	35%	30%
% of Providers with Scores Less than 25%	53%	64%
Group 2	*N=37*	*N=39*
Median	19%	16%
Mean	35%	27%
% of Providers with Scores Less than 25%	57%	67%
Group 3	*N=32*	*N=33*
Median	10%	13%
Mean	23%	25%
% of Providers with Scores Less than 25%	72%	70%
Combined	N=101	N=86
Median	12%	14%
Mean	31%	27%
% of Providers with Scores Less than 25%	60%	67%

	Debt Ratio (DR)		
	Year:	*2009*	*2010*
Group 1		*N=32*	*N=14*
	Median	0.35	0.44
	Mean	0.53	0.51
	% of Providers with Scores .5 or Higher	42%	50%
Group 2		*N=37*	*N=39*
	Median	0.53	0.6
	Mean	0.59	0.61
	% of Providers with Scores .5 or Higher	55%	54%
Group 3		*N=32*	*N=33*
	Median	0.59	0.59
	Mean	0.62	0.59
	% of Providers with Scores .5 or Higher	66%	70%
Combined		*N=101*	*N=86*
	Median	0.54	0.55
	Mean	0.58	0.59
	% of Providers with Scores .5 or Higher	55%	58%

	Current Ratio (CR)		
	Year:	*2009*	*2010*
Group 1		*N=32*	*N=14*
	Median	2.29	1.66
	Mean	9.29	8.68
	% of Providers with Scores Below 1	25%	21%
	% of Providers with Scores Below 2	41%	71%
Group 2		*N=37*	*N=39*
	Median	1.32	1.29
	Mean	2.65	3.12
	% of Providers with Scores Below 1	37%	26%
	% of Providers with Scores Below 2	76%	67%
Group 3		*N=32*	*N=33*
	Median	1.48	1.61
	Mean	2.11	2.81
	% of Providers with Scores Below 1	13%	18%
	% of Providers with Scores Below 2	75%	73%
Combined		*N=101*	*N=86*
	Median	1.49	1.47
	Mean	4.59	3.91

Conclusions of Financial Analysis

1. The 11 Year Trend Analysis illustrates that the provider community has experienced a financial decline from the year 2000 to the year 2010.
2. Years without COLAs present a financial hardship to the providers. Repeated, successive years without COLAs have been difficult for providers to manage. During this period they have reduced expenses, like health care benefits to employees to be able to balance revenues and expenses. Opportunities for savings in their operations have been exhausted and there is little likelihood that continued operation without increases can be managed without service reductions.
3. A lack of funding increases that matches increases in expenses erodes the provider network's ability to change to meet service needs and reinvest in the network.
4. Rates should be set at a minimum to cover the costs of care. To create a strong network that can make the required system changes will require that providers are actually able to retain income for reinvestment.
5. In a service network that is moving to evidenced based service models, forced deviation from the model due to a lack of funding cannot be tolerated. The rate must be adequate to provide the service as outlined by the evidenced based practice to have the desired results.

Recommendations

We recommended the following as necessary for the preservation of quality services and assuring the financial viability of the community nonprofit agencies providing humans services in Connecticut.

Consensus Recommendations

1. Reporting and Data

a. State Agencies shall develop a plan to standardize financial reporting requirements for all Providers. This plan shall include deadlines and reportable outcomes for such standardization of financial reporting.

b. The impact of all new administrative requirements shall be considered prior to implementation. Agencies will work with Providers to mitigate the impact.

c. As of July 1, 2014 many Providers must have systems in place that comply with Federal Meaningful Use Requirements. This will provide a commonality of file structure which can guide State data collection system development. It is the recommendation that all state agencies be required to, where appropriate, pursue avenues to take advantage of the common file structure in their data collection systems. These systems shall allow for standardized and secure upload.

d. There will be ongoing aggregation of audit data by the State and review of the CT Non Profit Strategy Platform data. An annual trend report will be performed by the Office of Policy and Management and where possible supported by the CT Non Profit Strategy Platform. It will be reviewed annually by the Governor's Cabinet on Non Profit Health and Human Services.

2. Sustainability

a. Allow not-for-profit organizations to have and maintain Capital Reserve Accounts not subject to audit recoupment as approved by Funding Agencies.

b. Cost standards for real estate should be reviewed and revised. Areas to be considered include but are not limited to: a land fair rental factor, and supplemental funding once depreciation and interest no longer meet a typical mortgage cost.

c. Create a system for approving no-cost budget revisions that is standardized across all agencies.

d. Payment rates shall cover the true cost of service as mutually agreed by Provider and Agency and be established in a fair and transparent manner. In years without a COLA, payment rates and service capacity should be reviewed to evaluate and respond to the changing costs where possible and appropriate.

e. Extraordinary one time increases in essential costs should be considered for supplemental funding, similar to what has been given to grantees for fuel relief in the past. This doesn't make a commitment to sustaining an increase from year to year like a COLA increase but does recognize fixed costs that are outside of a provider's control and offer some relief.

f. Donated real estate is an opportunity for Non Profit Providers to improve their financial situation. Current cost report rules result in the state deriving the primary annual benefit of such a donation. The provider community and the state Agencies should discuss ways to allow the Providers to have a greater benefit in the state funding system through depreciation or other means where it is of mutual interest.

Majority Recommendations

1. Sustainability

a. Risk must be shared by both the state and providers. The state should consider the issue of provider surplus retention up to a defined amount for providers that meet performance outcomes and receive agency approval. Safeguards will be put in place to ensure this is not attained by holding down wages and benefits or constriction of services. The providers should have an opportunity to retain some savings through careful management. Partial surplus retention encourages good business practices and allows for a portion of unspent contract dollars to be reinvested into the provider infrastructure on which the state depends.

Appendix 1: Impact of No Cost of Service Increases for Community Based Providers

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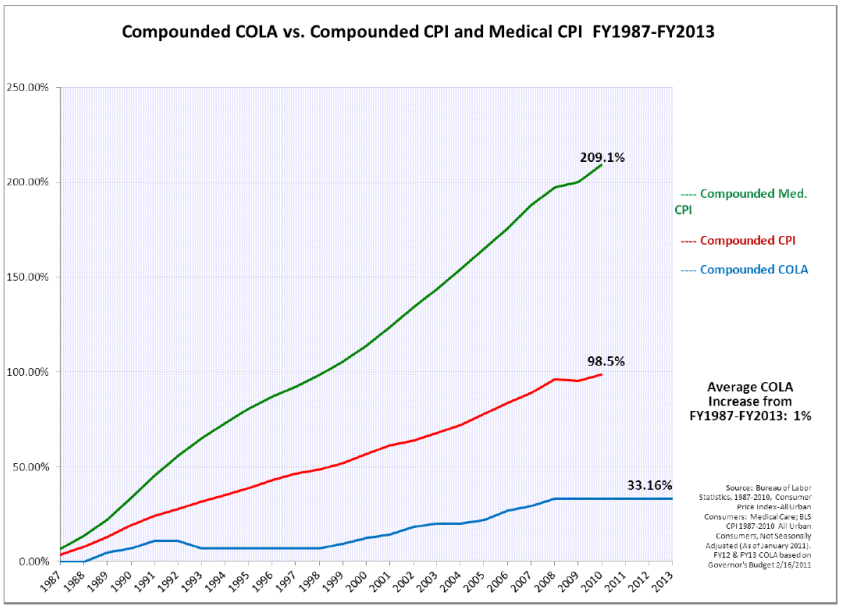
Impact of No Cost of Service Increases for Nonprofit Community-Based Providers

2/17/12

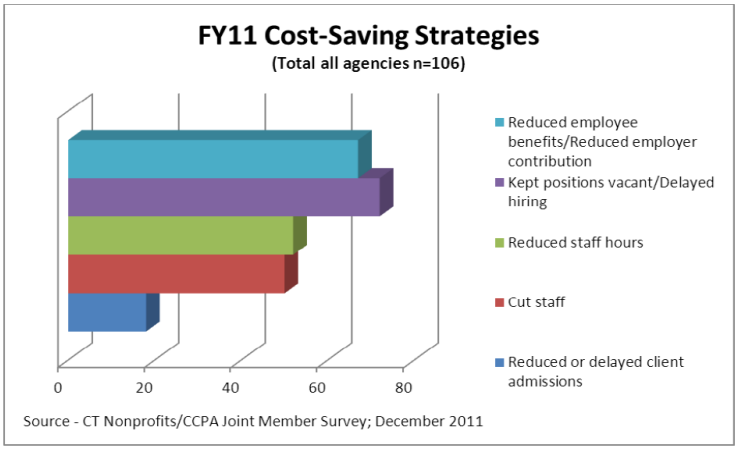
Nonprofit community-based providers that represent the state's safety net are currently in the fourth year of no cost-of-living adjustments (COLA) on their state contracts or fee-for-service rates. Providers have also faced three years of rescissions and budget reductions leaving them in a tenuous position.



From 1986 to 2010, the compounded Consumer Price Index (CPI), which is the measure of the average change over time in the prices paid by consumers for goods and services, increased 98.5% while the compounded Medical CPI rose by 209.1%. Meanwhile, during the same time period the state's COLA for nonprofit community-based providers increased by only 33.2%.

In a recent joint survey completed by CT Nonprofits and CCPA of their memberships, when asked what cost-saving mechanisms they implemented during FY11 in response to three years of no COLAs, the majority of respondents reported that their three main methods of coping with underfunding were a reduction to employee benefits, keeping positions vacant and delaying hiring.

Despite employing innovative strategies to maximize efficiencies, such as entering into collaborations with other providers, implementing green technologies, engaging web-based solutions and billing systems that maximize revenues, and consolidating programs, providers have still been forced to take steps that negatively impact the state's economy.



Source - CT Nonprofits/CCPA Joint Member Survey; December 2011

Appendix 2: Human Service Funding by State Agencies

DCF			
	Service	**Programs**	**Funding**
Generic Grouping			
Addiction Services			
	Drug Treatment	6	$1,173,950
	Substance Abuse	11	$3,591,660
Adoption/Foster Care Services			
	Foster & Adoption Recruitment & Retention	5	$281,761
	Foster Care Support	1	$2,002,248
	Foster Family Support	1	$48,769
	Multi Dimensional Foster Care	1	$944,855
	Yes2Kids Adoption	2	$109,728
Behavioral Health Services			
	BH Out Of Home Fee for Service	0	$3,531,736
	Child Guidance Clinic	26	$11,805,156
	Community Life Skills	21	$1,023,397
	Emergency Mobile Psych. Services	8	$10,141,794
	Extended Day Treatment	19	$6,575,963
	Local Systems of Care	1	$390,000
	Therapeutic Child Care	2	$655,945
Child Protective Services			
	CPS Community Based Fee for Service	0	$14,269,235
	CPS Out of Home Fee for Service	0	$34,030,985
	Family Advocacy	1	$400,000
	Family Based Recovery / SAFAR	5	$1,638,119
	Family Enrichment	2	$79,520
	Family Support	10	$6,409,984
	Family Violence	7	$895,280
	Outreach, Tracking and Reunification (OTR)	8	$3,210,980
	Parent Education	33	$5,386,758
	Reunification/Visitation	16	$1,460,371
	Supportive Housing for Recovering Families	1	$12,840,910
Employment Services			
	Youth Employment Training	2	$690,000

In-Home Services (Evidence Based)			
	Multi-Systemic Therapy	13	$4,341,301
	MDFT	2	$396,870
	IICAPS	1	$506,760
	Intensive Family Preservation	19	$4,882,223
	Intensive Family Preservation Enhancement	4	$613,385
	Family Support Team	1	$33,735
In-Home Services (Other)			
	In-Home Services	35	$6,920,310
Forensic Services			
	JJ Community Based Services	0	$0
	JJ Educ Re-Entry & Delinq Prev	1	$583,000
	JJ Intermediate Evaluation	5	$2,130,000
	Juvenile Criminal Diversion	8	$476,911
	Juvenile Review Board	5	$659,144
	Forensic Interviews	2	$94,364
	Prison Transportation	3	$61,775
24 Hour Residential Programs			
	Group Home	2	$2,010,784
	Group Home POP DMHAS	44	$41,007,634
	Therapeutic Group Home	7	$6,795,169
	Residential Treatment - JJ	1	$90,000
	JJ Group Home	1	$978,070
	Safe Home	13	$15,271,006
	Short Term Assessment & Respite	12	$8,837,400
	Short Term Residential & Sub-Acute Residential	3	$2,647,731
	Miscellaneous-Independent Living	2	$1,285,055
Other			
	Care Coordination	3	$792,863
	Coordination Services	10	$3,380,000
	Early Childhood	3	$2,568,507
	Enhanced Care Coordination	1	$8,881
	FAST	5	$1,665,018
	Mentoring	5	$86,015
	Multi-Disciplinary Examinations	14	$956,046
	Multi-Disciplinary Teams	25	$1,860,341
	Neighborhood Youth Center	2	$251,010
Total		441	$235,780,412

DMHAS			
	Service	**Programs**	**Funding**
Generic Grouping			
Addiction Services			
	Advocacy and Prevention	115	$13,225,487
Behavioral Health Services			
	Emergency / Crisis	19	$8,711,012
	Outpatient	139	$44,792,874
	Case Management (includes CSP, RP)	139	$41,404,665
	Rehabilitation	85	$25,804,279
24 Hour Residential Programs			
	Residential Treatment (includes Group homes)	85	$35,925,620
	Residential Treatment (MRO)	20	$5,255,968
	Housing	194	$70,002,684
Other			
	Education and Training	0	$0
	Special Programs (includes YAS, ABI, Forensic)	34	$9,794,706
	MH Hospital Inpatient	16	$3,589,804
	SA Hospital Inpatient	1	$50,000
Total		847	$258,557,099

DDS			
	Service	**Programs**	**Funding**
Generic Grouping			
Behavioral Health Services			
	Clinical Behavioral Support Services	0	$1,377,275
Employment Services			
	Group Supported Employment	60	$63,391,483
	Sheltered Employment	13	$7,768,782
	Individualized Supported Employment	43	$4,731,918
In-Home Services (Other)			
	Individualized Home Supports	56	$42,057,292
24 Hour Residential Programs			
	Residential Schools	29	$14,128,444
	Community Living Arrangements	78	$320,534,892
	Continuous Residential Settings	57	$53,028,804
	Community Companion Homes	271	$6,425,412
	Community Companion Home Provider Support	8	$2,125,397
Other			
	Adult Companion	0	$1,137,711
	Adult Day Health	0	$292,630
	Birth to Three	40	$40,244,770
	Day Service Options	80	$90,640,795
	Health Care Coordination	0	$61,081
	Individualized Day	59	$23,435,919
	Personal Supports	0	$15,406,570
	Respite - Daily	0	$1,704,947
	Respite - Hourly	0	$1,172,787
	Transportation (when not part of program rate)	0	$4,296,604

Total	794	$693,963,513

	CSSD		
	Service	**Programs**	**Funding**
Generic Grouping			
Addiction Services			
	SA Group	27	$2,259,109
Behavioral Health Services			
	Assessments	0	$1,973,993
	SA, AM & MH Groups	2	$244,754
	SA & MH Groups	2	$167,987
	AM Groups	21	$732,291
	MH Groups	19	$264,961
	MH Individual	26	$1,398,367
	Medication Assisted TX	30	$305,408
	IOP	25	$6,608,322
Total		152	$13,955,192

	DOC		
	Service	**Programs**	**Funding**
Generic Grouping			
24-Hr Residential Programs			
	Residential Work Release	25	$19,142,673
	Residential Substance Abuse	11	$5,073,875
	Residential Mental Health	1	$590,457
	Residential Women & Children	1	$801,932
	Residential Temporary Housing	4	$1,298,545
	Residential Scattered-Site Supportive Housing	7	$3,568,975
	Residential Sex Offender Treatment	1	$1,000,000
Behavioral Health Services			
	Non-Residential Behavioral Health	11	$3,253,864
Employment Services			
	Non-Residential Employment	5	$2,055,138
Forensic Services			
	Non-Residential Social Reunification	5	$706,995
	Non-Residential Support Services	3	$806,170
	Non-Residential One Stop Multi Service	5	$1,576,182
	Non-Residential Sex Offender Treatment	1	$571,971
	Non-Residential ReEntry Program	1	$495,000
Total		81	$40,941,777

APPENDIX E

Cross-Agency Population Results Working Group's

Final Report to

The Governor's Cabinet on Nonprofit Health and Human Services

June 15, 2012

Cross-Agency Population Results Statements
Working Group Membership List

William Carbone, Co-chair, Executive Director, Judicial Branch Court Support Services Division

Nancy Roberts, Co-chair, President, Connecticut Council for Philanthropy

Yvette H. Bello, Executive Director, Latino Community Services

Maureen Price-Boreland, Executive Director, Community Partners in Action

Yolanda Caldera-Durant, Program Associate, Annie E. Casey Foundation

Michelle Cook, State Representative, 65th Assembly District - Torrington.

Kathleen Brennan, Deputy Commissioner, Department of Social Services.

Charlene Russell-Tucker, Chief of Staff, State Department of Education.

Brian Hill, Deputy Director II, Judicial Branch Court Support Services Division

Cathy FoleyGeib, Manager of Administrative Services II, Judicial Branch Court Support Services Division

Anne McIntyre-Lahner, Program Director, Department of Children and Families

Patrick Hynes, Director - Best Practices Unit, Department of Correction

Janet Brancifort, MPH, Public Health Services Manager, Department of Public Health

Karin Haberlin, Behavioral Health Program Manager, Department of Mental Health & Addiction Services

Timothy Deschenes-Desmond, Planning Specialist, Department of Developmental Services

Mark Polzella, Director of Employment Services Department of Labor

Susan Keane, Senior Committee Administrator, Appropriations Committee, Connecticut General Assembly

Consulting Members

Susan Simmat, Policy Development Coordinator, Office of Policy and Management

Peter DeBiasi, President/CEO, The *Access* Community Action Agency

Bennett Pudlin, The Charter Oak Group, LLC

Ajit Gopalakrishnan, Education Consultant and GED Administrator, State Department of Education

Working Group Charge

1. Using a Results-Based Accountability (RBA) framework, create a comprehensive set of Population Results Statements for use by government and nonprofit Health and Human Services agencies.
2. Identify Headline and Secondary Indicators that provide a method for measuring progress toward the Population Results Statements.
3. Identify a Data Development Agenda for each Population Result Statement that identifies gaps in data availability.

Background

Meetings

The Cross Agency Population Results Working Group met seven times between December 6, 2011 and May 22, 2012. Meetings were held at the offices of Judicial Branch, Court Support Services Division, the Connecticut Council for Philanthropy and the Legislative Office Building. Copies of meeting minutes can be found on the Cabinet's website.

Organization of the Working Group

The Working Group was divided into five working groups according to broad domains intended to encompass the work of health and human services agencies: (1) Safety, (2) Success in School, (3) Healthy, (4) Success in Life for Disabled and Elderly Persons, and (5) Employment and Self-Sufficiency. The workgroups were led by Brian Hill, Charlene Russell-Tucker, Yvette Bello, Kathleen Brennan, and Yolanda Caldera-Durant, respectively.

Presentations, Guest Speakers, and Technical Assistance

Bennett Pudlin from the Charter Oak Group provided technical assistance throughout the project to the Co-chairs and to each of the five working groups. His expertise in Results-Based Accountability was invaluable to the Working Group's work.

Working Group members who had not attended training on Results-Based Accountability attended one of two RBA 101 trainings conducted by the Charter Oak Group in January and the Annie E. Casey Foundation in February. This training was essential to ensure all Working Group members were grounded in the language of RBA.

Susan Keane, Senior Committee Administrator for the General Assembly's Appropriations Committee, and Barry Goff from the Charter Oak Group presented to the Working Group on 12/6/11 regarding the RBA work over the past seven years led by her committee. Ms. Keane was added to the Working Group membership to ensure coordination of efforts on these RBA initiatives.

Julia Wilcox, Senior Public Policy Specialist, from Connecticut Nonprofits attended several meetings as a guest and to provide insight from the nonprofit sector broadly.

Working Group Chairs, William Carbone and Nancy Roberts, met with Senator Toni Harp and Representative Toni Walker, Co-chairs of the General Assembly's Appropriations Committee, on April 26, 2012 to review and solicit feedback on each of the result statements and associated indicators.
The Working Group's proposed Population Results Statements and Headline/Secondary Indicators were reviewed by a number of state and nonprofit agencies prior to finalization. The technical

assistance and feedback received from these agencies was invaluable. The list of agencies that provided assistance and feedback includes, but is not limited to: The United Way of Connecticut, Connecticut Association of Nonprofits, the Community Action Agency of New Haven, the Charter Oak Group, the William Caspar Graustein Memorial Fund, Departments of Social Services, Mental Health and Addiction Services, Public Health, the PSC Housing & The Reaching Home CT Coordinating Committee, The Donaghue Foundation, the Access Community Action Network, the Connecticut Housing Coalition, the Select Committee on Children's "Children's Report Card" committee.

Data, Information, Studies, etc. used to support findings, recommendations and conclusions

Budgeting for Results Commission Report, State of Illinois, Governor Pat Quinn. November 2011

RBA Reports Cards submitted to the General Assembly, 2009-2012, and all human services result statements contained in RBA materials presented to the Appropriations Committee by state agencies, 2005-2012.

Disruptive Forces: Driving a Human Services Revolution. Alliance for Children and Families, 2011

Fair and Accountable: Partnership Principles for a Sustainable Human Services System. Donor's Forum, 2010.

State of Connecticut: Commission on Nonprofit Health and Human Services (2011). *Final Report, Special Act 10-5*.

Findings

First, the Working Group found substantial overlap with the RBA work of the General Assembly's Appropriations Committee and the Select Committee on Children. Much of the early work of the Working Group focused on creating a comprehensive inventory of Population Results Statements (also known as *Quality of Life Results*). Over thirty existing Population Results Statements submitted by Health and Human Services agencies were categorized in one of thirteen initial domains. For clarity and communication power, the results statements were ultimately arranged in five domains and working groups were formed with the charge of developing a single results statement for each domain. The workgroup results statement recommendations (found in Appendix A) mirrored much of the work done in Connecticut to date.

Second, each of the five Population Results Statements includes suggested headline and secondary indicators that will help to identify progress toward each result. These indicators are provided as an initial list of possible indicators for each results statement. The development of indicators at the population level of RBA is often an iterative process, dependent on data availability and quality. This process will likely include the creation of a Data Development Agenda that included data not currently collected or available.

Third, the Working Group unanimously voted to acknowledge and include the work of the Select Committee on Children's RBA Report Card as a sixth Population Results Statement. This report card has been the product of a diverse working group that includes representatives from the General Assembly, the executive and judicial branches, the nonprofit sector, local government, parents, child advocates and higher education. Addressing children from birth to age 18, this report card provides both a result statement and well-refined headline and secondary indicators, which are being publicly reported.

A copy of the Children's Report Card can be found in *Appendix B.*

Finally, The Connecticut Data Collaborative offered to support the Governor's Cabinet on Nonprofit Health and Human Services in reporting indicators for the cross-agency population results statements adopted by the Cabinet. When the indicators are finalized and technically defined (operationalized), the Collaborative will work with the relevant state agencies to obtain the necessary data on an ongoing basis and will add the indicators to the Data Catalog on the Collaborative's web site, ctdata.org. In addition, the Collaborative will create for the Cabinet a customized data portal on ctdata.org where the public can easily access and visualize the indicators by result.

Consensus Recommendations

Consensus Recommendation

1. State government and nonprofit agencies should locate their RBA Report Card and budget submission work under one or more of the following Population Result Statements:
    a. All Connecticut residents live in safe families and communities;
    b. All Connecticut residents are economically secure;
    c. All Connecticut residents are developmentally, physically, and mentally healthy across the life span;
    d. All Connecticut residents who are elderly (65+) or have disabilities live engaged lives in supportive environments of their choosing;
    e. All Connecticut residents succeed in education and are prepared for careers, citizenship, and life;
    (Found following the Working Group conclusions)
    f. All children grow up in a stable environment, safe, healthy, & ready to succeed (from *CT Children's Report Card, found in Appendix B*).

    (*NOTE: The complete recommended Populations Results, and related Indicators of success and Data Development Agendas appear in Appendix B of this report.)*

    Indicators are intended to be disaggregated at various levels, where appropriate and available (e.g. race/ethnicity, socioeconomic status, disability, geography, age).

    State government and nonprofit agencies can customize these Population Result Statements to focus on the quality of life of the specific populations they serve, if needed.

2. An organizing body should be established to implement and oversee this work. A broad and diverse group that includes representation from each branch of state government and nonprofit agencies should be assembled under the direction of an appointed coordinator.

Majority Recommendations: None

Next Steps: Operationalize the headline and secondary indicators by gathering the needed data and identifying gaps in data collection.

Conclusion

The Cross Agency Population Results Statements Working Group appreciates the opportunity to organize a diverse group of stakeholder in the development of common results statements. We believe the recommendations set forth in this final report will provide a solid foundation for the continuation of the use of RBA across state government and the nonprofit sector.